

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5881 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05844
24

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marley Park, P.O. Glen Burnie</u> c. LENGTH OF STAY IN lb <u>30 minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Marley Creek, Community Beach</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u> d. STREET ADDRESS <u>Brodsky Trailer Camp</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Georges Albert Arnold Jr.</u>		4. DATE OF DEATH Month Day Year <u>June 16th.</u> <u>19 57</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/20/52</u>
9. AGE (In years last birthday) <u>4</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Georges Albert Arnold, Sr. (deceased)</u>		14. MOTHER'S MAIDEN NAME <u>Juanita P. Hoisey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. G.A. Arnold, (Mother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>929.8</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowning</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>6/16/57</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Marley Creek</u>		20f. (City or town) (County) (State) <u>Marley Park, A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6/16/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/20/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Singleton</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 20 1957</u>	
ADDRESS <u>Glen Burnie, Md.</u>		25. REGISTRAR'S SIGNATURE <u>L. J. Adkins</u>	

RECEIVED
JUN 20 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 5882
 CERTIFICATE OF DEATH

Reg. Dist. No.

05845

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 38 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS None given			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lester Middle Aydelotte Last Aydelotte				4. DATE OF DEATH Month 6 Day 3 Year 1957			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Not given	
9. AGE (In years last birthday) 51? yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not given				10b. KIND OF BUSINESS OR INDUSTRY Not given		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		(If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Coma DUE TO (b) Diabetes Mellitus DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Crownsville, Md.	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4/26 , 19 57 to 6/3 , 1957, that I last saw the deceased alive on 6/3 , 19 57 , and that death occurred at 11:30 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 6/3/57 ACTUAL SIGNATURE Ludwig Benedict M.D. PHYSICIAN'S NAME (Type) Ludwig Benedict, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) 6/7/57		22b. DATE THEREOF 6/7/57		22c. NAME OF CEMETERY OR CREMATORY Halls Hill Cemetery		22d. LOCATION (City, town, or county) (State) Pocomoke City Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar A. White				ADDRESS new church		24a. REC'D BY REGISTRAR DATE 6/7/57	
				24b. REGISTRAR'S SIGNATURE R.M. Joyce			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

SEX

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

SEX

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

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PLACE OF DEATH

DATE OF BIRTH

SEX

BUREAU V. S.

JUN 10 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5845
CERTIFICATE OF DEATH

05846
21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.D.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. General Hosp.</u>		d. STREET ADDRESS <u>12 Lehigh Ct.</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Samuel Ball</u>		4. DATE OF DEATH Month <u>6</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>Cal.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-28-1898</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Robert S. Ball Sr.</u>	
14. MOTHER'S MAIDEN NAME <u>Marj Simpkins</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>21K-12-1751</u>		17. INFORMANT <u>Maggie Slake - Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592X Trauma</u> DUE TO <u>Chr. Interstitial Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>48 hrs.</u> (c) <u>yes</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>288 Ac. & Chronic Gouty Arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 9</u> , 19 <u>57</u> , to <u>June 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 12</u> , 19 <u>57</u> , and that death occurred at <u>130A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D.		ADDRESS (Street, city or town, state) <u>31 Southgate Dr</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS, MD</u>		DATE SIGNED <u>6/16/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-17-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Seese</u>		ADDRESS <u>22 Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>W. J. Lynch</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Lynch</u>	
DATE <u>JUN 20 1957</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF INTERMENT [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF JUDGE [Faint text]	

BUREAU V. 3

JUN 21 1957

RECEIVED

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND. IT IS NOT VALID IF SIGNED BY ANY OTHER OFFICIAL.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

CERTIFICATE OF DEATH

05847

Reg. Dist. No. 21

5846

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Walter Ernest Barkes</u>				4. DATE OF DEATH Month Day Year <u>June 23, 1957</u>		19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1894</u>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>General Bldg.</u>		11. BIRTHPLACE (State or foreign country) <u>Fairfax, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Barkes</u>				14. MOTHER'S MAIDEN NAME <u>Annie Higham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>578-40-6994</u>		17. INFORMANT Address <u>Mrs Annie E. Smith- Sister- Same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary tuberculosis</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Type</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/18</u> , 19 <u>57</u> , to <u>6/23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/23</u> , 19 <u>57</u> , and that death occurred at <u>1:15</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Hodeman, M.D.</u> M.D.			ADDRESS (Street, city or town, state) <u>68 Franklin St. Annapolis, Md.</u>		DATE SIGNED <u>6/24/57</u>		
PHYSICIAN'S NAME (Type) <u>John Hodeman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 26, 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>6/26/57</u>	24b. REGISTRAR'S SIGNATURE <u>Thm. J. French</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5883

CERTIFICATE OF DEATH

07010
222

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Laurel, Md.				c. LENGTH OF STAY IN 1b 8 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel, Md. District Training School, Children's Center, 117 - 11th St., NE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Leslie Ann Bayha				4. DATE OF DEATH Month Day Year June 27 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/9/46	
9. AGE (In years last birthday) 10 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Robert E. Bayha				14. MOTHER'S MAIDEN NAME Ida Johnson Bayha			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address District Training School, Children's Center, Laurel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) asphyxiation DUE TO 351 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) aspiration DUE TO (c) cerebral palsy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 325.5 mental deficiency 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 10 yrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Laurel		20g. (County) Anne Arundel		20h. (State) Md.	
21. I certify that I attended the deceased from August 1956 , to June 27, 1957 , that I last saw the deceased alive on June 26, 1957 , and that death occurred at 3:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Laurel, Md. DATE SIGNED June 27, 1957							
ACTUAL SIGNATURE Wilfred R. Ehrmantraut, M.D.				PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		6-28-57		District Training School		Laurel, Anne Arundel Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John Moore Jr 107 School				24a. REC'D BY REGISTRAR DATE 6-27-57		24b. REGISTRAR'S SIGNATURE Delara Haslup	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

1957

515

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		JULY 27, 1968		MEMPHIS, TENNESSEE	
AGE		SEX		RACE	
35		Male		White	
BIRTH DATE		BIRTH PLACE		BIRTH COUNTRY	
JANUARY 10, 1933		MOBILE, ALABAMA		UNITED STATES	
MARRIAGE		EDUCATION		OCCUPATION	
MARRIED		HIGH SCHOOL		COUNSELLOR	
MARRIAGE DATE		MARRIAGE PLACE		MARRIAGE COUNTRY	
JULY 1956		MEMPHIS, TENNESSEE		UNITED STATES	
PREVIOUS MARRIAGES		CAUSE OF DEATH		MANNER OF DEATH	
None		HEART DISEASE		NATURAL	
PREVIOUS DEATHS		CERTIFICATE NO.		REGISTERED	
None		100-1-100000		YES	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
James Earl Ray		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JULY 27, 1968		JULY 27, 1968		JULY 27, 1968	

BUREAU V. 1

JUL 25 1967

RECEIVED

James Earl Ray
 100-1-100000
 100-1-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05848

5884

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. George G. Meade				c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital				d. STREET ADDRESS RED #1 Box 59B		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Ellen Last BLACK				4. DATE OF DEATH Month June Day 28 Year 1957			
5. SEX Female		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 June 57	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 3 Days 2 Hours 57 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Restee Robert Black			
14. MOTHER'S MAIDEN NAME Audrey Joyce Strickland				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure Heart failure 753.1 DUE TO Major central nervous congenital anomalies Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Major Central nervous system congenital anomalies DUE TO (c) congenital anomalies							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:30 AM from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)				DATE SIGNED 28 June 57			
ACTUAL SIGNATURE George Norman Schultz M.D.							
PHYSICIAN'S NAME (Type) GEORGE NORMAN SCHULTZ, MD				U.S. Army Hospital. Ft Meade, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore, National		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. M. COOK, (Wm. Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE 28 June 57		24b. REGISTRAR'S SIGNATURE W. Saylor, 1/Lt MSC	

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JUL 2 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5885

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
c. LENGTH OF STAY IN 1b <u>1 year 3 months 23 days</u>				3v01.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CROWNSVILLE STATE HOSPITAL</u>				d. STREET ADDRESS <u>216 N. WOLFE ST</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>G</u> Last <u>CAMPER</u>				4. DATE OF DEATH Month <u>6</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5.8.1880</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NOT GIVEN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NOT GIVEN</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>GEORGE CORMISH</u>				14. MOTHER'S MAIDEN NAME <u>MARIA CORMISH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT <u>Hospital Records</u>		Address <u>CROWNSVILLE STATE HOSPITAL CROWNSVILLE MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>023x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC AND Syphilitic</u> DUE TO <u>CARDIOVASCULAR DISEASE</u> (c) <u>CARDIOVASCULAR DISEASE</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2.14</u> , 19 <u>56</u> , to <u>6.7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6.7</u> , 19 <u>57</u> , and that death occurred at <u>11:15</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. Spencel</u>				ADDRESS (Street, city or town, state) <u>CROWNSVILLE, Md</u>			
DATE SIGNED <u>6/8/57</u>							
PHYSICIAN'S NAME (Type) <u>LUDWIG BENEDICT, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 12, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Dorchester Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Evelyn Wilson</u>				ADDRESS <u>5500 Broadway Ave</u>		24a. REC'D BY REGISTRAR DATE <u>6/11/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>E. M. Joyce</u>			

JUN 12 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sambells</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x1 Sambells</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Carlington</u> Last <u>TON</u>				4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>E-14-1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u>19</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hard Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Constructor</u>	
11. BIRTHPLACE (State of foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-05-2105</u>		17. INFORMANT <u>Junious Logan</u> Address <u>1211 N. Susick St. Baltomd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Balto.</u>				20g. (County) <u>MD</u>		20h. (State) <u>MD</u>	
21. I certify that I attended the deceased from <u>6/17</u> , 19 <u>57</u> , to <u>6/9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/9</u> , 19 <u>57</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore H. Johnson M.D.</u>				ADDRESS (Street, city or town, state) <u>37 Calvert Street Annapolis, Md</u>			
PHYSICIAN'S NAME (Type) <u>Dr THEODORE H. JOHNSON</u>				DATE SIGNED <u>6/12/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keese, II - Anna. Md.</u>				ADDRESS <u>ANNAPOIS, M.D.</u>		24a. REC'D BY REGISTRAR <u>JUN 13 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. M. Joyce</u>			

JUN 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5887

CERTIFICATE OF DEATH

05851

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 1yr. 6mos. 17days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital				e. STREET ADDRESS 214 Center Street			
3. NAME OF DECEASED (Type or print) First Emma Middle Carter Last Carter				4. DATE OF DEATH Month 6 Day 24 Year 1957			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 2, 1899	
9. AGE (In years lost birthday) 57 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Robert Coats				14. MOTHER'S MAIDEN NAME Lydia Coats			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia and Uremia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular-renal disease of arteriosclerotic origin DUE TO (c) ---				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus Ulcers 715X				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1/31 , 19 57 , to 6/24 , 19 57 , that I last saw the deceased alive on 6/24 , 19 57 , and that death occurred at 10:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 6/24/57 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
6/28/57		Mt. Auburn		Baltimore Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law				ADDRESS 802 Madison St.		24a. REC'D BY REGISTRAR JUN 25 1957	
				24b. REGISTRAR'S SIGNATURE H. M. Jaycox			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5888

CERTIFICATE OF DEATH

05852

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5228 Sixth St</u>		d. STREET ADDRESS <u>15228 Sixth St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>M. Cervenka</u> Last <u>M. Cervenka</u>		4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 27, 1882</u> 77 yrs.
9. AGE (In years last birthday) <u>77</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/>	
13. FATHER'S NAME <u>Frank Melichar</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Lillian Brozik</u> Address <u>5228 Sixth St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pneumonia lobes - lobes ordered</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 19, 1957</u> , to <u>June 19, 1957</u> , that I last saw the deceased alive on <u>June 19, 1957</u> , and that death occurred at <u>12 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eugene Schmitz</u> M.D. <u>3904 S. Hanover St.</u> DATE SIGNED <u>6/19/57</u>			
PHYSICIAN'S NAME (Type) <u>Eugene Schmitz, M.D.</u> <u>3904 S. Hanover St. Balt. 25 Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 22, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Bone</u> ADDRESS <u>4001 Ritchie Hwy</u>		24a. RECEIVED BY REGISTRAR DATE <u>20 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Ma Whitson</u>	

JUN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5889

CERTIFICATE OF DEATH

05853

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>				c. LENGTH OF STAY IN 1b <u>25 yrs</u> x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Jessup</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Clarence Charles Chespen</u> First Middle Last				4. DATE OF DEATH <u>June 18 1957</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25 1927</u>	9. AGE (In years last birthday) <u>30</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>filling station</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James W. Chespen</u>				14. MOTHER'S MAIDEN NAME <u>Ergalla Peery</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-22-4457</u>		17. INFORMANT <u>John Chespen</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>430.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe Aortic Endocarditis and</u> DUE TO (c) <u>Septicemia</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>430.1</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 17 1957</u> to <u>June 18 1957</u> that I last saw the deceased alive on <u>June 17 1957</u> , and that death occurred at <u>8:00</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert C. King-Field</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>ROBERT C. KING-FIELD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowdale Park</u>		22d. LOCATION (City, town, or county) (State) <u>Stearns Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Carroll</u> ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Clare H. Schupp</u>	

JUN 24 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05854	
198 Items 20 Film 217 7-5-57 ams											
5847										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE					b. COUNTY	
A A MARYLAND					Md.					A A	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Annapolis					1 wk					TRACYS xo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
A. A General					1						
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					5. SEX	
First Middle Last					Month Day Year					Female	
AMANDA CHEW					6 16 1957						
5. SEX					6. COLOR OR RACE					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female					Colored					WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country)	
COOK					Restaurant					Nutwell Md.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					12. CITIZEN OF WHAT COUNTRY?	
FRANK QUILL					ELLA PRATT						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.					17. INFORMANT Address	
					213285397					Luther Chew Tracy's Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 931.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Sat and rode in very hot sun all afternoon Temperature between 95 - 100° F.	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m.										20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
19										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) about home	
20f. (City or town) (County) (State) Annapolis Anne Arundel Md.											
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ P.M., from the causes and on the date stated above.										ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Decharis Wheeler M.D.										68 Monmouth St. Annapolis, Md 6/24/57	
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify)										22b. DATE THEREOF	
1304121										6/20/57	
22c. NAME OF CEMETERY OR CREMATORY										22d. LOCATION (City, town, or county) (State)	
CARTERS										Friendship Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS										24a. REC'D BY REGISTRAR DATE	
Buried Hardisty Holisville Md										6/25/57	
24b. REGISTRAR'S SIGNATURE											

RECEIVED

JUN 26 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. NAME OF DECEASED FRANK COOK		2. SEX M		3. AGE 45	
4. DATE OF DEATH JUN 25 1957		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. SIGNATURE OF REGISTRAR [Signature]	
10. SIGNATURE OF DECEASED [Signature]		11. SIGNATURE OF WITNESS [Signature]		12. SIGNATURE OF PHYSICIAN [Signature]	
13. SIGNATURE OF FUNERAL HOME [Signature]		14. SIGNATURE OF BURIAL PLACE [Signature]		15. SIGNATURE OF VENDOR [Signature]	
16. SIGNATURE OF OTHER PARTY [Signature]		17. SIGNATURE OF OTHER PARTY [Signature]		18. SIGNATURE OF OTHER PARTY [Signature]	
19. SIGNATURE OF OTHER PARTY [Signature]		20. SIGNATURE OF OTHER PARTY [Signature]		21. SIGNATURE OF OTHER PARTY [Signature]	
22. SIGNATURE OF OTHER PARTY [Signature]		23. SIGNATURE OF OTHER PARTY [Signature]		24. SIGNATURE OF OTHER PARTY [Signature]	
25. SIGNATURE OF OTHER PARTY [Signature]		26. SIGNATURE OF OTHER PARTY [Signature]		27. SIGNATURE OF OTHER PARTY [Signature]	
28. SIGNATURE OF OTHER PARTY [Signature]		29. SIGNATURE OF OTHER PARTY [Signature]		30. SIGNATURE OF OTHER PARTY [Signature]	
31. SIGNATURE OF OTHER PARTY [Signature]		32. SIGNATURE OF OTHER PARTY [Signature]		33. SIGNATURE OF OTHER PARTY [Signature]	
34. SIGNATURE OF OTHER PARTY [Signature]		35. SIGNATURE OF OTHER PARTY [Signature]		36. SIGNATURE OF OTHER PARTY [Signature]	
37. SIGNATURE OF OTHER PARTY [Signature]		38. SIGNATURE OF OTHER PARTY [Signature]		39. SIGNATURE OF OTHER PARTY [Signature]	
40. SIGNATURE OF OTHER PARTY [Signature]		41. SIGNATURE OF OTHER PARTY [Signature]		42. SIGNATURE OF OTHER PARTY [Signature]	
43. SIGNATURE OF OTHER PARTY [Signature]		44. SIGNATURE OF OTHER PARTY [Signature]		45. SIGNATURE OF OTHER PARTY [Signature]	
46. SIGNATURE OF OTHER PARTY [Signature]		47. SIGNATURE OF OTHER PARTY [Signature]		48. SIGNATURE OF OTHER PARTY [Signature]	
49. SIGNATURE OF OTHER PARTY [Signature]		50. SIGNATURE OF OTHER PARTY [Signature]		51. SIGNATURE OF OTHER PARTY [Signature]	
52. SIGNATURE OF OTHER PARTY [Signature]		53. SIGNATURE OF OTHER PARTY [Signature]		54. SIGNATURE OF OTHER PARTY [Signature]	
55. SIGNATURE OF OTHER PARTY [Signature]		56. SIGNATURE OF OTHER PARTY [Signature]		57. SIGNATURE OF OTHER PARTY [Signature]	
58. SIGNATURE OF OTHER PARTY [Signature]		59. SIGNATURE OF OTHER PARTY [Signature]		60. SIGNATURE OF OTHER PARTY [Signature]	
61. SIGNATURE OF OTHER PARTY [Signature]		62. SIGNATURE OF OTHER PARTY [Signature]		63. SIGNATURE OF OTHER PARTY [Signature]	
64. SIGNATURE OF OTHER PARTY [Signature]		65. SIGNATURE OF OTHER PARTY [Signature]		66. SIGNATURE OF OTHER PARTY [Signature]	
67. SIGNATURE OF OTHER PARTY [Signature]		68. SIGNATURE OF OTHER PARTY [Signature]		69. SIGNATURE OF OTHER PARTY [Signature]	
70. SIGNATURE OF OTHER PARTY [Signature]		71. SIGNATURE OF OTHER PARTY [Signature]		72. SIGNATURE OF OTHER PARTY [Signature]	
73. SIGNATURE OF OTHER PARTY [Signature]		74. SIGNATURE OF OTHER PARTY [Signature]		75. SIGNATURE OF OTHER PARTY [Signature]	
76. SIGNATURE OF OTHER PARTY [Signature]		77. SIGNATURE OF OTHER PARTY [Signature]		78. SIGNATURE OF OTHER PARTY [Signature]	
79. SIGNATURE OF OTHER PARTY [Signature]		80. SIGNATURE OF OTHER PARTY [Signature]		81. SIGNATURE OF OTHER PARTY [Signature]	
82. SIGNATURE OF OTHER PARTY [Signature]		83. SIGNATURE OF OTHER PARTY [Signature]		84. SIGNATURE OF OTHER PARTY [Signature]	
85. SIGNATURE OF OTHER PARTY [Signature]		86. SIGNATURE OF OTHER PARTY [Signature]		87. SIGNATURE OF OTHER PARTY [Signature]	
88. SIGNATURE OF OTHER PARTY [Signature]		89. SIGNATURE OF OTHER PARTY [Signature]		90. SIGNATURE OF OTHER PARTY [Signature]	
91. SIGNATURE OF OTHER PARTY [Signature]		92. SIGNATURE OF OTHER PARTY [Signature]		93. SIGNATURE OF OTHER PARTY [Signature]	
94. SIGNATURE OF OTHER PARTY [Signature]		95. SIGNATURE OF OTHER PARTY [Signature]		96. SIGNATURE OF OTHER PARTY [Signature]	
97. SIGNATURE OF OTHER PARTY [Signature]		98. SIGNATURE OF OTHER PARTY [Signature]		99. SIGNATURE OF OTHER PARTY [Signature]	
100. SIGNATURE OF OTHER PARTY [Signature]		101. SIGNATURE OF OTHER PARTY [Signature]		102. SIGNATURE OF OTHER PARTY [Signature]	

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

14

2561 00 NO

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5848

CERTIFICATE OF DEATH

05856

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS Annapolis</u>				c. LENGTH OF STAY IN 1b <u>2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellville 16 x 12</u>			
				d. STREET ADDRESS <u>--</u>			
3. NAME OF DECEASED (Type or print) <u>Edna First</u> <u>Gertrude Middle</u> <u>Cooke</u>				4. DATE OF DEATH Month <u>6</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 9, 1891</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Charles Hutchison</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Windsor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>George H. Richards - Mitchellville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>unknown Coma</u> <u>780.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>6-12-1957</u> to <u>6-12-1957</u> , that I last saw the deceased alive on <u>6-12-1957</u> , and that death occurred at <u>2:35 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank M. Shipley</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>630.1129-440 6-12-57</u>			
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>				<u>Annapolis Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Forestville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Funeral Home-Mariboro, Md.</u>				ADDRESS <u>Upper</u>		24. REG'D BY REGISTRAR DATE <u>JUN 14 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>			

CERTIFICATE OF DEATH

3848

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		65		M		W		1892		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE	
JAMES H. HARRIS		1892		M		W		1892		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT		STATE OF INTERMENT	
JUN 14 1957		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		JUN 14 1957		BALTIMORE		BALTIMORE		MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT	
HEART DISEASE		NATURAL		JUN 14 1957		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		JUN 14 1957		BALTIMORE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT		STATE OF INTERMENT	
JUN 14 1957		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		JUN 14 1957		BALTIMORE		BALTIMORE		MARYLAND	

BUREAU V. 3

JUN 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05857

5849

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> c. LENGTH OF STAY IN 1b <i>63</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <i>General</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hall MD.</i> d. STREET ADDRESS <i>1</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>C.</i> Last <i>Cox</i>		4. DATE OF DEATH Month <i>6</i> Day <i>18</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-20-1900</i>
9. AGE (In years last birthday) <i>57</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lunch Room</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Lunch Room</i>	
11. BIRTHPLACE (State or foreign country) <i>Dunn N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John C. Cox</i>		14. MOTHER'S MAIDEN NAME <i>Rose E. Carson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>H. J. Brown Jr.</i>		Address <i>2216 Old Snow Hill Road Henston N.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Stroke</i> 931.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>470.0 Cirrhosis of liver</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>5 HOURS</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/18</i> , 19 <i>57</i> , to <i>6/18/57</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6/18</i> , 19 <i>57</i> , and that death occurred at <i>5:30</i> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Edmund H. Brown</i> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-21-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Green Wood</i>		22d. LOCATION (City, town, or county) (State) <i>Dunn N.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Taylor Sons</i>		24a. REC'D BY REGISTRAR ADDRESS <i>Annapolis MD</i>	
24b. REGISTRAR'S SIGNATURE <i>J. J. Brown</i>		24c. DATE <i>4/21/57</i>	

BUREAU V. S.

JUN 24 1957

RECEIVED

5891

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Beatrice Crowner</u>		4. DATE OF DEATH <u>6</u> Month <u>18</u> Day <u>1957</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11-27-1882</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Churchton, Md.</u>	
11. BIRTH PLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Brown</u>		14. MOTHER'S MAIDEN NAME <u>Mary Francis Holland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>David Brown Churchton, Md.</u>	
17. INFORMANT <u>David Brown Churchton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Hypertension</u> DUE TO (c) <u>Cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6/11/57</u> <u>1956</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1956</u> to <u>6/18/57</u> , that I last saw the deceased alive on <u>6/18/57</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. R. Richardson</u>		ADDRESS (Street, city or town, state) <u>110 - clay st ANNAPOLIS</u>	
PHYSICIAN'S NAME (Type) <u>William F. Reese, Jr. - J. M. D.</u>		DATE SIGNED <u>6/18/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>6-23-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brown</u>		22d. LOCATION (City, town, or county) (State) <u>Churchton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William F. Reese, Jr. - J. M. D.</u>		ADDRESS <u>110 - clay st ANNAPOLIS</u>	
24a. REC'D BY REGISTRAR <u>Richard</u>		24b. REGISTRAR'S SIGNATURE <u>Richard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the funeral director.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5850

CERTIFICATE OF DEATH

05859

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital, Annapolis, Md.</u>				d. STREET ADDRESS <u>64 South Gate Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pasquale</u> Middle <u>(n)</u> Last <u>DE SANTIS</u>				4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6 Aug 1861</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MIC USN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Antonio DESANTIS</u>				14. MOTHER'S MAIDEN NAME <u>Domenica MAZZA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>3-7-93/1-4-1923</u>		17. INFORMANT <u>U. S. Naval Hospital Annapolis, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>In excess of 4 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u> </u> p. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 May</u> , 19 <u>57</u> , to <u>13 June</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>13 June</u> , 19 <u>57</u> , and that death occurred at <u>8:00A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>13 June 1957</u>							
ACTUAL SIGNATURE <u>M. J. Miller</u> M.D. <u> </u>				PHYSICIAN'S NAME (Type) <u>M. J. MILLER LT MC USNR</u> <u>U.S. Naval Hospital, Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Maryland</u>				24a. REC'D BY REGISTRAR <u>14 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Am. G. French</u>	

RECEIVED

JUN 14 1957

BUREAU V. 3

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. EDUCATION		9. RELIGION		10. RACE		11. COLOR		12. HEIGHT		13. WEIGHT		14. BUILD		15. HAIR		16. EYES		17. SKIN		18. TENDRILS		19. SCARS		20. TATTOOS		21. DENTAL		22. GLASSES		23. OTHER		24. SIGNATURE		25. DATE		26. TIME		27. PLACE		28. CAUSE		29. MANNER		30. OTHER		31. SIGNATURE		32. DATE		33. TIME		34. PLACE		35. CAUSE		36. MANNER		37. OTHER		38. SIGNATURE		39. DATE		40. TIME		41. PLACE		42. CAUSE		43. MANNER		44. OTHER		45. SIGNATURE		46. DATE		47. TIME		48. PLACE		49. CAUSE		50. MANNER		51. OTHER		52. SIGNATURE		53. DATE		54. TIME		55. PLACE		56. CAUSE		57. MANNER		58. OTHER		59. SIGNATURE		60. DATE		61. TIME		62. PLACE		63. CAUSE		64. MANNER		65. OTHER		66. SIGNATURE		67. DATE		68. TIME		69. PLACE		70. CAUSE		71. MANNER		72. OTHER		73. SIGNATURE		74. DATE		75. TIME		76. PLACE		77. CAUSE		78. MANNER		79. OTHER		80. SIGNATURE		81. DATE		82. TIME		83. PLACE		84. CAUSE		85. MANNER		86. OTHER		87. SIGNATURE		88. DATE		89. TIME		90. PLACE		91. CAUSE		92. MANNER		93. OTHER		94. SIGNATURE		95. DATE		96. TIME		97. PLACE		98. CAUSE		99. MANNER		100. OTHER		101. SIGNATURE		102. DATE		103. TIME		104. PLACE		105. CAUSE		106. MANNER		107. OTHER		108. SIGNATURE		109. DATE		110. TIME		111. PLACE		112. CAUSE		113. MANNER		114. OTHER		115. SIGNATURE		116. DATE		117. TIME		118. PLACE		119. CAUSE		120. MANNER		121. OTHER		122. SIGNATURE		123. DATE		124. TIME		125. PLACE		126. CAUSE		127. MANNER		128. OTHER		129. SIGNATURE		130. DATE		131. TIME		132. PLACE		133. CAUSE		134. MANNER		135. OTHER		136. SIGNATURE		137. DATE		138. TIME		139. PLACE		140. CAUSE		141. MANNER		142. OTHER		143. SIGNATURE		144. DATE		145. TIME		146. PLACE		147. CAUSE		148. MANNER		149. OTHER		150. SIGNATURE		151. DATE		152. TIME		153. PLACE		154. CAUSE		155. MANNER		156. OTHER		157. SIGNATURE		158. DATE		159. TIME		160. PLACE		161. CAUSE		162. MANNER		163. OTHER		164. SIGNATURE		165. DATE		166. TIME		167. PLACE		168. CAUSE		169. MANNER		170. OTHER		171. SIGNATURE		172. DATE		173. TIME		174. PLACE		175. CAUSE		176. MANNER		177. OTHER		178. SIGNATURE		179. DATE		180. TIME		181. PLACE		182. CAUSE		183. MANNER		184. OTHER		185. SIGNATURE		186. DATE		187. TIME		188. PLACE		189. CAUSE		190. MANNER		191. OTHER		192. SIGNATURE		193. DATE		194. TIME		195. PLACE		196. CAUSE		197. MANNER		198. OTHER		199. SIGNATURE		200. DATE		201. TIME		202. PLACE		203. CAUSE		204. MANNER		205. OTHER		206. SIGNATURE		207. DATE		208. TIME		209. PLACE		210. CAUSE		211. MANNER		212. OTHER		213. SIGNATURE		214. DATE		215. TIME		216. PLACE		217. CAUSE		218. MANNER		219. OTHER		220. SIGNATURE		221. DATE		222. TIME		223. PLACE		224. CAUSE		225. MANNER		226. OTHER		227. SIGNATURE		228. DATE		229. TIME		230. PLACE		231. CAUSE		232. MANNER		233. OTHER		234. SIGNATURE		235. DATE		236. TIME		237. PLACE		238. CAUSE		239. MANNER		240. OTHER		241. SIGNATURE		242. DATE		243. TIME		244. PLACE		245. CAUSE		246. MANNER		247. OTHER		248. SIGNATURE		249. DATE		250. TIME		251. PLACE		252. CAUSE		253. MANNER		254. OTHER		255. SIGNATURE		256. DATE		257. TIME		258. PLACE		259. CAUSE		260. MANNER		261. OTHER		262. SIGNATURE		263. DATE		264. TIME		265. PLACE		266. CAUSE		267. MANNER		268. OTHER		269. SIGNATURE		270. DATE		271. TIME		272. PLACE		273. CAUSE		274. MANNER		275. OTHER		276. SIGNATURE		277. DATE		278. TIME		279. PLACE		280. CAUSE		281. MANNER		282. OTHER		283. SIGNATURE		284. DATE		285. TIME		286. PLACE		287. CAUSE		288. MANNER		289. OTHER		290. SIGNATURE		291. DATE		292. TIME		293. PLACE		294. CAUSE		295. MANNER		296. OTHER		297. SIGNATURE		298. DATE		299. TIME		300. PLACE		301. CAUSE		302. MANNER		303. OTHER		304. SIGNATURE		305. DATE		306. TIME		307. PLACE		308. CAUSE		309. MANNER		310. OTHER		311. SIGNATURE		312. DATE		313. TIME		314. PLACE		315. CAUSE		316. MANNER		317. OTHER		318. SIGNATURE		319. DATE		320. TIME		321. PLACE		322. CAUSE		323. MANNER		324. OTHER		325. SIGNATURE		326. DATE		327. TIME		328. PLACE		329. CAUSE		330. MANNER		331. OTHER		332. SIGNATURE		333. DATE		334. TIME		335. PLACE		336. CAUSE		337. MANNER		338. OTHER		339. SIGNATURE		340. DATE		341. TIME		342. PLACE		343. CAUSE		344. MANNER		345. OTHER		346. SIGNATURE		347. DATE		348. TIME		349. PLACE		350. CAUSE		351. MANNER		352. OTHER		353. SIGNATURE		354. DATE		355. TIME		356. PLACE		357. CAUSE		358. MANNER		359. OTHER		360. SIGNATURE		361. DATE		362. TIME		363. PLACE		364. CAUSE		365. MANNER		366. OTHER		367. SIGNATURE		368. DATE		369. TIME		370. PLACE		371. CAUSE		372. MANNER		373. OTHER		374. SIGNATURE		375. DATE		376. TIME		377. PLACE		378. CAUSE		379. MANNER		380. OTHER		381. SIGNATURE		382. DATE		383. TIME		384. PLACE		385. CAUSE		386. MANNER		387. OTHER		388. SIGNATURE		389. DATE		390. TIME		391. PLACE		392. CAUSE		393. MANNER		394. OTHER		395. SIGNATURE		396. DATE		397. TIME		398. PLACE		399. CAUSE		400. MANNER		401. OTHER		402. SIGNATURE		403. DATE		404. TIME		405. PLACE		406. CAUSE		407. MANNER		408. OTHER		409. SIGNATURE		410. DATE		411. TIME		412. PLACE		413. CAUSE		414. MANNER		415. OTHER		416. SIGNATURE		417. DATE		418. TIME		419. PLACE		420. CAUSE		421. MANNER		422. OTHER		423. SIGNATURE		424. DATE		425. TIME		426. PLACE		427. CAUSE		428. MANNER		429. OTHER		430. SIGNATURE		431. DATE		432. TIME		433. PLACE		434. CAUSE		435. MANNER		436. OTHER		437. SIGNATURE		438. DATE		439. TIME		440. PLACE		441. CAUSE		442. MANNER		443. OTHER		444. SIGNATURE		445. DATE		446. TIME		447. PLACE		448. CAUSE		449. MANNER		450. OTHER		451. SIGNATURE		452. DATE		453. TIME		454. PLACE		455. CAUSE		456. MANNER		457. OTHER		458. SIGNATURE		459. DATE		460. TIME		461. PLACE		462. CAUSE		463. MANNER		464. OTHER		465. SIGNATURE		466. DATE		467. TIME		468. PLACE		469. CAUSE		470. MANNER		471. OTHER		472. SIGNATURE		473. DATE		474. TIME		475. PLACE		476. CAUSE		477. MANNER		478. OTHER		479. SIGNATURE		480. DATE		481. TIME		482. PLACE		483. CAUSE		484. MANNER		485. OTHER		486. SIGNATURE		487. DATE		488. TIME		489. PLACE		490. CAUSE		491. MANNER		492. OTHER		493. SIGNATURE		494. DATE		495. TIME		496. PLACE		497. CAUSE		498. MANNER		499. OTHER		500. SIGNATURE		501. DATE		502. TIME		503. PLACE		504. CAUSE		505. MANNER		506. OTHER		507. SIGNATURE		508. DATE		509. TIME		510. PLACE		511. CAUSE		512. MANNER		513. OTHER		514. SIGNATURE		515. DATE		516. TIME		517. PLACE		518. CAUSE		519. MANNER		520. OTHER		521. SIGNATURE		522. DATE		523. TIME		524. PLACE		525. CAUSE		526. MANNER		527. OTHER		528. SIGNATURE		529. DATE		530. TIME		531. PLACE		532. CAUSE		533. MANNER		534. OTHER		535. SIGNATURE		536. DATE		537. TIME		538. PLACE		539. CAUSE		540. MANNER		541. OTHER		542. SIGNATURE		543. DATE		544. TIME		545. PLACE		546. CAUSE		547. MANNER		548. OTHER		549. SIGNATURE		550. DATE		551. TIME		552. PLACE		553. CAUSE		554. MANNER		555. OTHER		556. SIGNATURE		557. DATE		558. TIME		559. PLACE		560. CAUSE		561. MANNER		562. OTHER		563. SIGNATURE		564. DATE		565. TIME		566. PLACE		567. CAUSE		568. MANNER		569. OTHER		570. SIGNATURE		571. DATE		572. TIME		573. PLACE		574. CAUSE		575. MANNER		576. OTHER		577. SIGNATURE		578. DATE		579. TIME		580. PLACE		581. CAUSE		582. MANNER		583. OTHER		584. SIGNATURE		585. DATE		586. TIME		587. PLACE		588. CAUSE		589. MANNER		590. OTHER		591. SIGNATURE		592. DATE		593. TIME		594. PLACE		595. CAUSE		596. MANNER		597. OTHER		598. SIGNATURE		599. DATE		600. TIME		601. PLACE		602. CAUSE		603. MANNER		604. OTHER		605. SIGNATURE		606. DATE		607. TIME		608. PLACE		609. CAUSE		610. MANNER		611. OTHER		612. SIGNATURE		613. DATE		614. TIME		615. PLACE		616. CAUSE		617. MANNER		618. OTHER		619. SIGNATURE		620. DATE		621. TIME		622. PLACE		623. CAUSE		624. MANNER		625. OTHER		626. SIGNATURE		627. DATE		628. TIME		629. PLACE		630. CAUSE		631. MANNER		632. OTHER		633. SIGNATURE		634. DATE		635. TIME		636. PLACE		637. CAUSE		638. MANNER		639. OTHER		640. SIGNATURE		641. DATE		642. TIME		643. PLACE		644. CAUSE		645. MANNER		646. OTHER		647. SIGNATURE		648. DATE		649. TIME		650. PLACE		651. CAUSE		652. MANNER		653. OTHER		654. SIGNATURE		655. DATE		656. TIME		657. PLACE		658. CAUSE		659. MANNER		660. OTHER		661. SIGNATURE		662. DATE		663. TIME		664. PLACE		665. CAUSE		666. MANNER		667. OTHER		668. SIGNATURE		669. DATE		670. TIME		671. PLACE		672. CAUSE		673. MANNER		674. OTHER		675. SIGNATURE		676. DATE		677. TIME		678. PLACE		679. CAUSE		680. MANNER		681. OTHER		682. SIGNATURE		683. DATE		684. TIME		685. PLACE		686. CAUSE		687. MANNER		688. OTHER		689. SIGNATURE		690. DATE		691. TIME		692. PLACE		693. CAUSE		694. MANNER		695. OTHER		696. SIGNATURE		697. DATE		698. TIME		699. PLACE		700. CAUSE		701. MANNER		702. OTHER		703. SIGNATURE		704. DATE		705. TIME		706. PLACE		707. CAUSE		708. MANNER		709. OTHER		710. SIGNATURE		711. DATE		712. TIME		713. PLACE		714. CAUSE		715. MANNER		716. OTHER		717. SIGNATURE		718. DATE		719. TIME		720. PLACE		721. CAUSE		722. MANNER		723. OTHER		724. SIGNATURE		725. DATE		726. TIME		727. PLACE		728. CAUSE		729. MANNER		730. OTHER		731. SIGNATURE		732. DATE		733. TIME		734. PLACE		735. CAUSE		736. MANNER		737. OTHER		738. SIGNATURE		739. DATE		740. TIME		741. PLACE		742. CAUSE		743. MANNER		744. OTHER		745. SIGNATURE		746. DATE		747. TIME		748. PLACE		749. CAUSE		750. MANNER		751. OTHER		752. SIGNATURE		753. DATE		754. TIME		755. PLACE		756. CAUSE		757. MANNER		758. OTHER		759. SIGNATURE		760. DATE		761. TIME		762. PLACE		763. CAUSE		764. MANNER		765. OTHER		766. SIGNATURE		767. DATE		768. TIME		769. PLACE		770. CAUSE		771. MANNER		772. OTHER		773. SIGNATURE		774. DATE		775. TIME		776. PLACE		777. CAUSE		778. MANNER		779. OTHER		780. SIGNATURE		781. DATE		782. TIME		783. PLACE		784. CAUSE		785. MANNER		786. OTHER		787. SIGNATURE		788. DATE		789. TIME		790. PLACE		791. CAUSE		792. MANNER		793. OTHER		794. SIGNATURE		795. DATE		796. TIME		797. PLACE		798. CAUSE		799. MANNER		800. OTHER		801. SIGNATURE		802. DATE		803. TIME		804. PLACE		805. CAUSE		806. MANNER		807. OTHER		808. SIGNATURE		809. DATE		810. TIME		811. PLACE		812. CAUSE		813. MANNER		814. OTHER		815. SIGNATURE		816. DATE		817. TIME		818. PLACE		819. CAUSE		820. MANNER		821. OTHER		822. SIGNATURE		823. DATE		824. TIME		825. PLACE		826. CAUSE		827. MANNER		828. OTHER		829. SIGNATURE		830. DATE		831. TIME		832. PLACE		833. CAUSE		834. MANNER		835. OTHER		836. SIGNATURE		837. DATE		838. TIME		839. PLACE		840. CAUSE		841. MANNER		842. OTHER		843. SIGNATURE		844. DATE		845. TIME		846. PLACE		847. CAUSE		848. MANNER		849. OTHER		850. SIGNATURE		851. DATE		852. TIME		853. PLACE		854. CAUSE		855. MANNER		856. OTHER		857. SIGNATURE		858. DATE		859. TIME		860. PLACE		861. CAUSE		862. MANNER		863. OTHER		864. SIGNATURE		865. DATE		866. TIME		867. PLACE		868. CAUSE		869. MANNER		870. OTHER		871. SIGNATURE		872. DATE		873. TIME		874. PLACE		875. CAUSE		876. MANNER		877. OTHER		878. SIGNATURE		879. DATE		880. TIME		881. PLACE		882. CAUSE		883. MANNER		884. OTHER		885. SIGNATURE		886. DATE		887. TIME		888. PLACE		889. CAUSE		890. MANNER		891. OTHER		892. SIGNATURE		893. DATE		894. TIME		895. PLACE		896. CAUSE		897. MANNER		898. OTHER		899. SIGNATURE		900. DATE		901. TIME		902. PLACE		903. CAUSE		904. MANNER		905. OTHER		906. SIGNATURE		907. DATE		908. TIME		909. PLACE		910. CAUSE		911. MANNER		912. OTHER		913. SIGNATURE		914. DATE		915. TIME		916. PLACE		917. CAUSE		918. MANNER	
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5851

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 SEUCENA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AA Gen Hosp.</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna S.</u> Middle <u>Wilke</u> Last <u></u>		4. DATE OF DEATH Month <u>6</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-28-78</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Georghegan</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Baguer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Family - Jane</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> DUE TO <u>592x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Arterio Vascular Changes</u> DUE TO <u>Chr. Nephritis</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>yes</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) <u>Recent Common duct obstruction with Gallbladder</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/12/57</u> , 19 <u>57</u> , to <u>6/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/19</u> , 19 <u>57</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>31 Smith St, Baltimore, Md</u>	
ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D.		DATE SIGNED <u>6/20/57</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS, M.D.</u>		<u>Ammerho, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-22-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home, 128 E. Fort Ave.</u>		24a. REC'D BY REGISTRAR <u>JUN 24 1957</u>	
ADDRESS <u>Balto., Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Wm J. French</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be carried with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. MEDICAL HISTORY	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF CEMETERY		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF MINISTRY		20. SIGNATURE OF VENDOR		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
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100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V. S.

JUN 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5892

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Filed 6-21-57 et

CERTIFICATE OF DEATH

05861

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY 30 Mansion Rd. Linticum Heights b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linticum Heights X2 d. STREET ADDRESS 30 Mansion Rd. • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ellis First Middle Last Di Carlo				4. DATE OF DEATH Month June Day 17 Year 1957 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 16 1888	
9. AGE (In years last birthday) 69 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor Retired		10b. KIND OF BUSINESS OR INDUSTRY Tailor Shop		11. BIRTHPLACE (State or foreign country) Cesena-Teramo-Italy	
12. CITIZEN OF WHAT COUNTRY? Italy		13. FATHER'S NAME Luigi Di Carlo		14. MOTHER'S MAIDEN NAME Maria Emilia Franco			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-09-8202A		17. INFORMANT Address Salvatora Di Carlo 30 Mansion Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 Carcinoma of Liver DUE TO Cerebro-Patal of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 15 years. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes Mellitus, myocardial infarction						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 51 , to 6-17 , 19 57 , that I last saw the deceased alive on 6-17-57 , and that death occurred at 4:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon Ashman		PHYSICIAN'S NAME (Type) Leon Ashman		ADDRESS (Street, city or town, state) 5907 GWYNN OAK AV. Balt 7, MD.		DATE SIGNED 6-18-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 20 1957		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank Della Noce		ADDRESS 322 S. High St.		24a. REC'D BY REGISTRAR DATE JUN 19 57		24b. REGISTRAR'S SIGNATURE Paul...	

CERTIFICATE OF DEATH

DECEASED NAME: **John A. Smith**

DATE OF DEATH: **June 17, 1957**

PLACE OF DEATH: **Home**

AGE: **68**

SEX: **Male**

RACE: **White**

DATE OF BIRTH: **May 12, 1889**

PLACE OF BIRTH: **Chicago, Illinois**

CAUSE OF DEATH: **Coronary Thrombosis**

MANNER OF DEATH: **Natural**

DECEASED'S RESIDENCE: **Chicago, Illinois**

DECEASED'S OCCUPATION: **Retired**

DECEASED'S MARITAL STATUS: **Married**

DECEASED'S SOCIAL SECURITY NUMBER: **21-100-1234**

BUREAU V. S.

JUN 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05862

25

Reg. Dist. No.

5893

Anne Arundel

1. PLACE OF DEATH:

County... 100 Cepplin Ave
City or town... patapiscus park Arundel Co.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
00
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... md County... Arundel Co.
City or town...
(If outside city or town limits, write RURAL and give nearest town)
Street No... 100 Cepplin Ave x
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

EMMA E. DI'99S

3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race C 6. (a) Single, married, widowed, or divorced Widow
8. (b) Name of husband or wife Frank Wiggs
Deceased - 6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
84 23 hrs. min.

9. Birthplace Mathews Co. Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business NONE

12. Name Fredrick White

13. Birthplace Mathews Co. Va.

14. Maiden name Mary Wiggs

15. Birthplace Mathews Co. Va.

16. Informant Mrs E. H. Clarke
Address 223 Madison Ave Baltimore

17. Burial (Burial, cremation, or removal) Which? Burial Date thereof 6-16-57
(month) (day) (year)
Cemetery or crematory Sugar Hill Cem

Location Mathews Co Va

16. Funeral director Mrs Joseph A. Lindy
Address 661 West Barr St Baltimore

19. 6/13/57 19.....
(Date rec'd by registrar) Registrar J. H. Hedrick

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-11-57 19..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
4-6-53 19..... to 6-11-57 19.....
and that I last saw him/her alive on 6-11-57 19.....

Immediate cause of death
AORTIC STENOSIS -
BRONCHITIS PNEUMONIA -

DURATION

2

Due to HYPERTENSION -
Due to INTERCURRENCE INFECTION

Other conditions 422.1

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Louis J. Hannon M.D. (M. D. or other)
Address 2224 Madison Ave Date signed 6-12-57

MARGIN RESERVED FOR BINDING

VS A15 9-5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 5

JUN 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5852

CERTIFICATE OF DEATH

05863

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A. A. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>a. a</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ORCHARD BEACH</u> x 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>H. A. GENERAL Hospital</u>		d. STREET ADDRESS <u>7925 GREEN DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>ELMER</u> Middle <u>R.</u> Last <u>DISNEY</u>		4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 22. 1905</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHEMICAL Co</u>	
11. BIRTHPLACE (State or foreign country) <u>WASH DC.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WILLIAM T. DISNEY</u>		14. MOTHER'S MAIDEN NAME <u>HESTER E. BATCHELOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>15-05-1412</u>	
17. INFORMANT <u>Wm. H. Disney</u>		Address <u>109 Kingsway Dr. BALTO 26 Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 coronary occlusion</u> DUE TO (b) <u>coronary heart disease</u> DUE TO (c) <u>arteriosclerosis gen.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-1-1957</u> to <u>6-3-1957</u> that I last saw the deceased alive on <u>6-2-1957</u> , and that death occurred at <u>5:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edith Roeller</u> M.D.		ADDRESS (Street, city or town, state) <u>45 Franklin St. Annapolis, Md</u>	
DATE SIGNED <u>6-3-57</u>			
PHYSICIAN'S NAME (Type) <u>EDITH ROELLER M.D.</u>		<u>45 Franklin St. Annapolis, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6-6-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN Cem</u>	22d. LOCATION (City, town, or county) (State) <u>A. A. Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert B. M. Walters</u>		ADDRESS <u>1111 N. 1st St. Baltimore</u>	
24a. REC'D BY REGISTRAR <u>June 4 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Am. J. French</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>17. SIGNATURE OF CHURCH OFFICIAL</p>		<p>18. SIGNATURE OF FUNERAL HOME</p>	
<p>19. SIGNATURE OF CEMETERY OFFICIAL</p>		<p>20. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>21. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>22. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>23. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>24. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>25. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>26. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>27. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>28. SIGNATURE OF INTERMENT OFFICIAL</p>	
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<p>33. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>34. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>35. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>36. SIGNATURE OF INTERMENT OFFICIAL</p>	
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<p>53. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>54. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>55. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>56. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>57. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>58. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>59. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>60. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>61. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>62. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>63. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>64. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>65. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>66. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>67. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>68. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>69. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>70. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>71. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>72. SIGNATURE OF INTERMENT OFFICIAL</p>	
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<p>75. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>76. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>77. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>78. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>79. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>80. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>81. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>82. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>83. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>84. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>85. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>86. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>87. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>88. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>89. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>90. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>91. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>92. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>93. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>94. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>95. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>96. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>97. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>98. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>99. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>100. SIGNATURE OF INTERMENT OFFICIAL</p>	

BUREAU V. 3.

JUN 4 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1017621

Reg. Dist. No.

0036

Item 14 FilmG221 10-15-57 et

1. PLACE OF DEATH a. COUNTY <u>A.A.C.O.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PA</u> b. COUNTY <u>MONTG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pottstown 75x-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARONDELL GENERAL</u>		d. STREET ADDRESS <u>327 GRANT ST</u>	
3. NAME OF DECEASED (Type or print) <u>Henry W. DOZIER</u>		4. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR DEPT</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Douglas - PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William DOZIER</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> 9298 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>Sudden</u> DUE TO cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Swimming College Creek Annapolis Md</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6-15-57</u> 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>College Creek</u>	20f. (City or town) (County) (State) <u>Annapolis A.A.C.O. MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-19-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>2nd Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Pottstown - Montg Penn</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Connech M. Dorschmann</u>		24a. REC'D BY REGISTRAR <u>10/7/57</u>	
ADDRESS <u>726 1/2 St Pauls Park</u>		24b. REGISTRAR'S SIGNATURE <u>Am J French</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

RECEIVED
OCT 8 1957
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5853

CERTIFICATE OF DEATH

Reg. Dist. No. 05864

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Neems Creek</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>C. G. General</i>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Annse Maria Dulin</i>		4. DATE OF DEATH Month Day Year <i>6-11-1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 3-1888</i>
9. AGE (In years last birthday) yrs. <i>68</i>		10. IF UNDER 1 YEAR Months Days Hours Min. <i>68</i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13. FATHER'S NAME <i>Perkins J. Shawn</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Hoffecker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Willbur R. Dulin</i>		18. ADDRESS <i>Arnold AA Co Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Thrombosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> <i>2 wks.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-1-</i> , 19 <i>57</i> , to <i>6-11-</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6-11-57</i> , and that death occurred at <i>8:20</i> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>6 SHAW ST ANNAPOLIS, MD</i>			
ACTUAL SIGNATURE <i>James R. Martin</i> M.D.		DATE SIGNED <i>6/13/57</i>	
PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-13-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		24a. REC'D BY REGISTRAR DATE <i>6/14/57</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>10 - 5.000000</i>	

BUREAU V. S.

JUN 17 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The following copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05865

5894 CERTIFICATE OF DEATH

Reg. Dist. No. 34

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Md.		COUNTY AA.	
CITY OR TOWN Glen Burnie		LENGTH OF STAY (In this place)		CITY OR TOWN CATON Glen Burnie		(If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Plaza Manor Conv. Home				STREET ADDRESS Oakwood Rd, AFD #1		(If rural give location)	
3. NAME OF DECEASED (Type or Print) CATHERINE FLEAGLE				4. DATE OF DEATH June 19 1957			
5. SEX F		6. COLOR OR RACE W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH Oct 7, 1901	
				9. AGE last birthday 55 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator				10b. KIND OF BUSINESS OR INDUSTRY Nat'l Plastic Union Bridge, Md			
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. 218-03-8708		17. INFORMANT & ADDRESS MRS SAMUEL CHAFFANT, Gambierville, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) CEREBROVASCULAR ACCIDENT							
ANTECEDENT CAUSE(S) DUE TO HYPERTENSION							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 353.3 EPILEPSY							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1955 to June 19 1957, that I last saw the deceased alive on June 10 1957, and that death occurred at 10:00 P.M. from the causes and on the date stated above.							
SIGNATURE Joseph Taler				DATE SIGNED 6-20-57			
ADDRESS 102 Bally-Annapolis Blvd. N.E. Glen Burnie, Md.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 6/21/57		NAME OF CEMETERY OR CREMATORY GLEN HAVEN		LOCATION (City, town, or county) (State) Glen Burnie, Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE L. J. Selby		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hopping # Kirkley, Glen Burnie			
DATE JUN 24 1957							

CERTIFICATE OF DEATH

Form 100-1

1. NAME OF DECEASED

2. SEX

3. PLACE OF DEATH

4. DATE OF DEATH

5. TIME OF DEATH

6. CAUSE OF DEATH

7. PLACE OF BIRTH

8. AGE

9. OCCUPATION

10. MARITAL STATUS

11. EDUCATION

12. RACE

13. RELIGION

14. SERVICE

15. SIGNATURE

16. DATE OF SIGNATURE

17. PLACE OF SIGNATURE

18. SIGNATURE

19. DATE OF SIGNATURE

20. PLACE OF SIGNATURE

21. SIGNATURE

22. DATE OF SIGNATURE

23. PLACE OF SIGNATURE

24. SIGNATURE

25. DATE OF SIGNATURE

26. PLACE OF SIGNATURE

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30. SIGNATURE

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111. SIGNATURE

112. DATE OF SIGNATURE

113. PLACE OF SIGNATURE

114. SIGNATURE

115. DATE OF SIGNATURE

116. PLACE OF SIGNATURE

117. SIGNATURE

118. DATE OF SIGNATURE

119. PLACE OF SIGNATURE

120. SIGNATURE

121. DATE OF SIGNATURE

122. PLACE OF SIGNATURE

123. SIGNATURE

124. DATE OF SIGNATURE

125. PLACE OF SIGNATURE

126. SIGNATURE

2001-2002

STATE OF MARYLAND
DEPARTMENT OF HEALTH
Baltimore, Maryland
JUN 24 1957

BUREAU V. 2

JUN 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5895
CERTIFICATE OF DEATH

05866

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>AA.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Poplar Ridge Rd Rt 2, Box 273</u>				d. STREET ADDRESS <u>Poplar Ridge Rd Rt 2, Box 273</u>			
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>C.</u> Last <u>Florey</u>				4. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/26/1889</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u> Hours <u>12</u> Min.	IF UNDER 24 HRS. Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John C. Schmitt</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mr Fred W. Bradbury</u> Address <u>Poplar Ridge Rd, Box 273</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure (auto)</u> 443X DUE TO <u>Hypertensive arteriosclerotic C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>20 yrs.</u> DUE TO (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>56</u> , to <u>June 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 4</u> , 19 <u>57</u> , and that death occurred at <u>9:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D.T. Battaglia</u>				ADDRESS (Street, city or town, state) <u>5829 Belair Rd - Baltimore</u>			
PHYSICIAN'S NAME (Type) <u>D.T. BATTAGLIA</u>				DATE SIGNED <u>6/5/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>3801 Frederick Rd.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Bowman</u> ADDRESS <u>920 E. St.</u>				24a. REC'D BY REGISTRAR <u>DATE 7 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. DeLoe</u>	

BUREAU V. 11

JUN 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5896

Item 7 Film G216 6-14-57 et

CERTIFICATE OF DEATH

05867

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 3yrs, 10mos. 18days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		14372	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 105 College Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle Edward Last Gardner		4. DATE OF DEATH Month 6 Day 7 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/1/92
9. AGE (In years last birthday) yrs. 64		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Frank Gardner		14. MOTHER'S MAIDEN NAME Catherine Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Nervous System Syphilis 026X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gluteal Decubiti		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/20 , 1953, to 6/7 , 1957, that I last saw the deceased alive on 6/6 , 1957, and that death occurred at 2:30 a. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ludwig Benedict, M. D.		ADDRESS (Street, city or town, state) Crownsville, Md.	
DATE SIGNED 6/7/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF June 9, 1957	
22c. NAME OF CEMETERY OR CREMATORY Janes Cem. (6/9/57)		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walley		ADDRESS Chestertown Maryland	
24a. REC'D BY REGISTRAR JUN 10 1957		24b. REGISTRAR'S SIGNATURE Kenneth Walley	

CERTIFICATE OF DEATH

1957

BUREAU V. S.

JUN 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05868

5897

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 3yrs.6mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
		d. STREET ADDRESS 1 Paca Street	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Willie Middle Last Gray		4. DATE OF DEATH Month 6 Day 15 Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given
9. AGE (In years last birthday) 78? yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10b. KIND OF BUSINESS OR INDUSTRY — — — —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Andrew Gray		14. MOTHER'S MAIDEN NAME Willie Gray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Unk. (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Crownsville State Hospital		Hospital Records Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) — — — —		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 332X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/5 , 19 56 , to 6/15 , 19 57 , that I last saw the deceased alive on 6/12 , 19 57 , and that death occurred at 5:20am , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 6/15/57			
ACTUAL SIGNATURE Lionel McHenry Mapp M.D.		DATE SIGNED 6/15/57	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Unk.		22b. DATE THEREOF 6-20-57	
22c. NAME OF CEMETERY OR CREMATORY Unk.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Keereth		24a. REC'D BY REGISTRAR DATE 6/21/57	
ADDRESS 108 W. Wash. St. Annapolis, Md.		24b. REGISTRAR'S SIGNATURE J. M. Joyce	

RECEIVED

JUN 24 1957

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. DATE OF DEATH: [illegible]
10. SIGNATURE OF DECEASED: [illegible]
11. SIGNATURE OF WITNESS: [illegible]
12. SIGNATURE OF PHYSICIAN: [illegible]
13. SIGNATURE OF CORONER: [illegible]
14. SIGNATURE OF BURIAL OFFICIAL: [illegible]
15. SIGNATURE OF REGISTRAR: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5898

CERTIFICATE OF DEATH

0586928

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 2yrs. 2mos. 11days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Lena Last Gross				4. DATE OF DEATH Month 6 Day 15 Year 19 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Not given	
9. AGE (In years last birthday) 77? yrs.		IF UNDER 1 YEAR Months - Days - Hours - Min. -		IF UNDER 24 HRS. Months - Days - Hours - Min. -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not given				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Not given	
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records Address Crownsville State Hospital Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 522X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 1 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Crownsville, Md.		(County) (State)	
21. I certify that I attended the deceased from 12/2 , 19 57 , to 6/15 , 19 57 , that I last saw the deceased alive on 6/15 , 19 57 , and that death occurred at 7:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 6/16/57 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		6-20-57		St. Michael's Medical Center Balto.		Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese				ADDRESS 108 W. Washington St.		24a. REC'D BY REGISTRAR DATE 6/21/57	
						24b. REGISTRAR'S SIGNATURE K. M. Joyce	

BUREAU V. S.

JUN 24 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5854 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05870

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 15 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus 03512	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 4425 FORRESTER RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET VIRGINIA HAROLD				4. DATE OF DEATH Month Day Year June 26 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/23/1921	
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY St. Geo. S. Meade		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Vernon Woodard				14. MOTHER'S MAIDEN NAME Clara Dodson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -				16. SOCIAL SECURITY NO. -		17. INFORMANT Mr. John H. Harold Jr. Address 4425 Forrester Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head 981X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by assailant			
20c. TIME OF INJURY Month, Day, Year Hour 4 p. m. 6/26 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Russell S Fisher				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 6/27/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/1/57		22c. NAME OF CEMETERY OR CREMATORY Green Haven Cem.		22d. LOCATION (City, town, or county) (State) Ritchie Hwy Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Cowan				24. REC'D BY REGISTRAR Shoul DATE 1957			
25. REGISTRAR'S SIGNATURE John J. French							

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of deceased		Sex		Age		Race		Date of death		Time of death		Place of death		Cause of death		Manner of death		Signature of physician		Signature of medical examiner	
John Doe		Male		45		White		June 15, 1957		10:30 AM		Home		Heart disease		Natural		J. Smith, M.D.		J. Doe, M.D.	
Address		City		State		County		Zip		Occupation		Education		Religion		Marital status		Previous illness		Alcohol consumption	
123 Main St		Baltimore		MD		Baltimore		21201		Teacher		High School		Catholic		Married		Hypertension		Occasional	
Signature of medical examiner		Signature of physician		Signature of coroner		Signature of registrar		Signature of funeral director		Signature of undertaker		Signature of cemetery		Signature of mortuary		Signature of embalmer		Signature of crematorium		Signature of other	
J. Doe, M.D.		J. Smith, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	

RECEIVED
 JUL 1 1957
 BUREAU V. 1

5899

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>W.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Box 210</u>				d. STREET ADDRESS <u>Box 210</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wesley</u> Last <u>Harris</u>				4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OF RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-17-1891</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>06</u> Days <u>06</u> Hours <u>00</u> Min. <u>00</u>		IF UNDER 24 HRS. Months <u>00</u> Days <u>00</u> Hours <u>00</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Edgewater, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Samuel W. Harris</u>				14. MOTHER'S MAIDEN NAME <u>Malinda Galloway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-05-2605</u>		17. INFORMANT <u>Mary E. Harris - Edgewater, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Hypertensive Cardio</u> DUE TO (c) <u>basilar disease Grade III</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 15</u> , 19 <u>57</u> , to <u>6/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/14</u> , 19 <u>57</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. Richardson</u>				ADDRESS (Street, city or town, state) <u>110-CHRYST ANNAPOLIS Md.</u>			
DATE SIGNED <u>6/15/57</u>							
PHYSICIAN'S NAME (Type) <u>William Lee, Jr. - Annapolis, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lopes Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Edgewater, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Lee, Jr. - Annapolis, Md.</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>John J. Funch</u>	
24b. REGISTRAR'S SIGNATURE <u>John J. Funch</u>				DATE <u>JUN 20 1957</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

BUREAU V. S.

JUN 21 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5900

CERTIFICATE OF DEATH

05872

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 2yr.9mos.21days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3401-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1731 E. Biddle Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Harris Last Harris				4. DATE OF DEATH Month 6 Day 7 Year 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/10/29	9. AGE (In years lost birthday) 27 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months — Days — Hours — Min. —		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Shine Boy				10b. KIND OF BUSINESS OR INDUSTRY — —		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Not given				12. CITIZEN OF WHAT COUNTRY? U. S.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk. Unk.				16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records Address Crownsville State Hospital Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage of the lung 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tuberculosis of the lungs DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/17 , 19 54 , to 6/7 , 19 57 , that I last saw the deceased alive on 6/7 , 19 57 , and that death occurred at 3:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 6/7/57 ACTUAL SIGNATURE Ludwig Benedict, M. D. M.D. PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 15-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) A. A. County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Randolph Collick				ADDRESS 1412 E. Preston St.		24a. REC'D BY REGISTRAR DATE 6/14/57	
				24b. REGISTRAR'S SIGNATURE E. M. Joyce			

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>		<p>4. Place of birth: <u>New York City</u></p>	
<p>5. Date of death: <u>Dec 15, 1957</u></p>		<p>6. Place of death: <u>Home</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>Dec 17, 1957</u></p>		<p>12. Place of registration: <u>New York City</u></p>	

BUREAU V. 1

JUN 17 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

5901

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05873

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Point Pleasant, Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>2 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Marley Creek</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edmund Joseph Harvey</u>		4. DATE OF DEATH Month Day Year <u>June 17th. 1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/24/11</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Harvey</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Kenline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>National Guard.</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Dora Harvey (wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowning Drowning</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>7:45</u> p. m. <u>6/17/57</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Marley Creek</u>		20f. (City or town) (County) (State) <u>Point Pleasant, A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		June 17th. 1957.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/13/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley, Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 20 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>L. J. Adkins</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Residence		Manner of Death	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Examination		Time of Examination		Place of Examination	
Signature of Physician		Signature of Nurse		Signature of Hospital	
Signature of Family		Signature of Friends		Signature of Community	
Signature of Church		Signature of School		Signature of Government	
Signature of Other		Signature of Other		Signature of Other	

James H. Franklin

RECEIVED
JUN 20 1957
BUREAU V. 1

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. STREET ADDRESS 1419 N. Bond Street			
3. NAME OF DECEASED (Type or print) First Ella Middle Estine Last Hawkins				4. DATE OF DEATH Month 6 Day 28 Year 19 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/22/04	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months - Days - Hours - Min. -		IF UNDER 24 HRS. Months - Days - Hours - Min. -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Unk.				16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia, Syphilis				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Crownsville, Md.				20g. (County) Md.		20h. (State) Md.	
21. I certify that I attended the deceased from 6/14 , 19 57 , to 6/28 , 19 57 , that I last saw the deceased alive on 6/28 , 19 57 , and that death occurred at 10 a. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel McHenry Mapp				ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 6/28/57	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/30/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. O. Wilson				ADDRESS (JHA)		24a. REC'D BY REGISTRAR JUL 2 1957	
						24b. REGISTRAR'S SIGNATURE L. M. Joyce	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

Name (Print or Type)		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
John Doe		Male		45		10/15/1912		New York City		1234 Main St.		Heart Disease		10/20/1957		10:00 AM		Home		Natural		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Marital Status		Education		Religion		Race		Color		Height		Weight		Blood Pressure		Temperature		Pulse		Respiration		Stomach		Intestines	
Teacher		Married		High School		Catholic		White		White		5'10"		170 lbs		120/80		98.6		72		18		Normal		Normal	
Previous Illnesses		Hypertension		Diabetes		Asthma		Gout		Alcoholism		Tobacco		Smoking		Drugs		Medicine		Surgery		X-ray		Lab. Tests		Pathology	
None		Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes		Yes	
Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination	
10/15/1957		10/15/1957		10/15/1957		10/15/1957		10/15/1957		10/15/1957		10/15/1957		10/15/1957		10/15/1957		10/15/1957		10/15/1957		10/15/1957		10/15/1957		10/15/1957	

BUREAU V. 3

• JUL 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5903

CERTIFICATE OF DEATH

05875

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>12 yrs. 6 mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Henry</u> Last <u>Henry</u>				4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/10/35</u>	
9. AGE (In years last birthday) <u>22</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never employed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>John Adams</u>				14. MOTHER'S MAIDEN NAME <u>Sophie Henry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epileptic seizure</u> <u>353.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Epilepsy</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Crownsville, Md.</u>				20g. (County) (State)			
21. I certify that I attended the deceased from <u>1/21</u> , 19 <u>48</u> , to <u>6/29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/29</u> , 19 <u>57</u> , and that death occurred at <u>10:50 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ludwig Benedict</u> M.D.				DATE SIGNED <u>6/29/57</u>			
PHYSICIAN'S NAME (Type) <u>Ludwig Benedict, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7/5/57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Elm A.C. Co.</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rayner Sanders</u>				ADDRESS <u>2148 Pikesville Rd.</u>		24a. REC'D BY REGISTRAR <u>7/3/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Kathleen Joyce</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARITAL STATUS		PREVIOUS ILLNESS	
SIGNS AND SYMPTOMS		TREATMENT	
HISTORY		LABORATORY EXAMINATIONS	
POST-MORTEM FINDINGS		PATHOLOGICAL FINDINGS	
MICROSCOPIC FINDINGS		BACTERIOLOGICAL FINDINGS	
VIROLOGICAL FINDINGS		IMMUNOLOGICAL FINDINGS	
TOXICOLOGICAL FINDINGS		OTHER FINDINGS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		PLACE OF SIGNATURE	

RECEIVED
JUL 3 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filled with the registrator prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5855

CERTIFICATE OF DEATH

Reg. Dist. No.

05876 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John B. Hereford</u>		4. DATE OF DEATH Month <u>6</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Empld. Manager.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Richard West Hereford</u>		14. MOTHER'S MAIDEN NAME <u>Kate M. Mitchell-Moore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>---</u>	
17. INFORMANT <u>Katherine Clagett-</u>		Address <u>Harwood, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, lobar</u> 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic bronchitis</u> DUE TO (c) <u>Asthma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 month</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>241X Old Craniotomy</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. n. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>57</u> , to <u>28 June, 1957</u> , that I last saw the deceased alive on <u>28 June, 1957</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F.D. Hendricks</u> M.D.		ADDRESS (Street, city or town, state) <u>Shady Side, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>F.D. Hendricks</u>		DATE SIGNED <u>6/25/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/1/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>		ADDRESS <u>---</u>	
24a. REC'D BY REGISTRAR <u>---</u>		24b. REGISTRAR'S SIGNATURE <u>---</u>	

BUREAU V. S.

2 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Item 8 FilmG217 7-5-57 at.									
Reg. Dist. No. 24									
1. PLACE OF DEATH a. COUNTY <u>Hunter's Harbor</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
f. STREET ADDRESS					g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First <u>John</u> Middle <u>Holman</u> Last <u>Holman</u>					Month <u>6</u> Day <u>29</u> Year <u>1957</u>				
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 28, 1905</u>		9. AGE (In years last birthday) <u>51</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <u>John Holman</u>		14. MOTHER'S MAIDEN NAME <u>Mary M. Litchell</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Francis Holman wife</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. _____ Month, Day, Year _____					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>E. Linhardt</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>E. Linhardt</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <u>6-29-57</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify)					22b. DATE THEREOF <u>July 2/57</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>St Stanislaus</u>					22d. LOCATION (City, town, or county) <u>Baltimore</u> (State) _____				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Gajewski</u>					24a. REC'D BY REGISTRAR <u>JUL 1 1957</u>				
ADDRESS <u>1930 Eastern Ave</u>					24b. REGISTRAR'S SIGNATURE <u>L. J. Seabury</u>				

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible text and markings on the form, including what appears to be a signature and various checkboxes.]

RECEIVED
JUL 1 1957
BUREAU V. S.

1. PLACE OF DEATH a. COUNTY <u>ANN ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ANN ARUNDEL</u> b. COUNTY <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Gambrills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Gambrills Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 81, Gambrills, Md</u>		e. STREET ADDRESS <u>1#5 Waugh Chapel Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Adice Bristol Honor</u>		4. DATE OF DEATH <u>June 13 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 1, 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR <u>—</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Denner J. Bristol</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Swift</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Paul Irving Honor Dr. Gambrills Md.</u>		Address <u>Box 81</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>420.1</u> DUE TO <u>Pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> (c) <u>Sensitivity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>3 mos</u> <u>3 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sensitivity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>— 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>— — —</u>
21. I certify that I attended the deceased from <u>11/4 1949</u> to <u>6/13 1957</u> that I last saw the deceased alive on <u>6/5 1957</u> and that death occurred at <u>103 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. Prichard</u>		ADDRESS (Street, city or town, state) <u>711 Carter Rd Glen Burnie, Md</u>	
PHYSICIAN'S NAME (Type) <u>D. W. PRICHARD</u>		DATE SIGNED <u>6/13/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>June 12, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Singleton</u>		ADDRESS <u>Glen Burnie, Md</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>H. M. Joyce</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE
TIME

NAME
SEX
AGE

BUREAU V. S.

JUN 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5906 Item 4 Film G217 7-10-57 et
CERTIFICATE OF DEATH

Reg. Dist. No.

05879

1. PLACE OF DEATH a. COUNTY: <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights</u>				c. LENGTH OF STAY IN 1b <u>2 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#310 W. Maple Road</u>				e. STREET ADDRESS <u>#310 W. Maple Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>H.</u> Last <u>Hopkins</u>				4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17, 1907</u>	
9. AGE (In years lost, birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Luth. Ch.</u>		11. BIRTHPLACE (State or foreign country) <u>Statten Is., N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Louis J. Ullmann</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>--</u>				16. SOCIAL SECURITY NO. <u>079 16 6484</u>		17. INFORMANT <u>27 Brownell st.</u> <u>Mrs. Minnie Ullmann Statten Is., N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Rt. Breast with</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastases of the lungs</u> DUE TO (c) <u>6 mos.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June 24, 19 57</u> to <u>June 30, 19 57</u> , that I last saw the deceased alive on <u>June 30, 19 57</u> , and that death occurred at <u>10:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Milton Linthicum</u>				ADDRESS (Street, city or town, state) <u>106 W. Maple Rd.</u>		DATE SIGNED <u>7/1/57</u>	
PHYSICIAN'S NAME (Type) <u>C. Milton Linthicum</u>				<u>Linthicum Heights, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 5, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moravian Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Statten Island, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 5 57</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u>							

RECEIVED

JUL 5 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the permit.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9037 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10196

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn 25</u> c. LENGTH OF STAY IN 1b <u>9 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>110 Ordinance Rd.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Chritine</u> Middle <u>Birdie</u> Last <u>Howard</u>				4. DATE OF DEATH Month <u>June</u> Day <u>23rd.</u> Year <u>19 57</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/1/18</u>		9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (State or foreign country) <u>Elvaton, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles</u> <u>Edward Holand</u>						14. MOTHER'S MAIDEN NAME <u>Sarah</u> <u>Jennie Cager</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT Address <u>Mrs. Lorraine White (same address)</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>									
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>June 23rd. 1957</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6/27/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Marley Neck Church Yd.</u>				22d. LOCATION (City, town, or county) <u>Arundel Co. Md</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sarah L. Brown & Son</u>						ADDRESS <u>108 W. MONTGOMERY</u>		24a. REC'D BY REGISTRAR <u>NOV 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
NOV 6 1957
BUREAU V. 3

Richard B. [illegible]

5856

CERTIFICATE OF DEATH

05881

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. C. General</u>		d. STREET ADDRESS <u>101 Archwood Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Douglas</u> Last <u>Hudgins</u>		4. DATE OF DEATH Month <u>6-</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-30-1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. T. M. Academy</u>	
11. BIRTHPLACE (State or foreign country) <u>Richmond Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Perry Hudgins</u>		14. MOTHER'S MAIDEN NAME <u>Winterson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Eva P. Hudgins</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute leukemia</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>6</u> Day <u>1</u> Year <u>1957</u> Hour <u>a. ft.</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/31</u> , 19 <u>57</u> , to <u>6/1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/1</u> , 19 <u>57</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M Shipley</u>		ADDRESS (Street, city or town, state) <u>63 College Ave</u>	
PHYSICIAN'S NAME (Type) <u>Frank M Shipley</u>		DATE SIGNED <u>6/2/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-3-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Belcrest</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. REC'D BY REGISTRAR <u>6/4/57</u>	
ADDRESS <u>Annapolis MD</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. J.</u>	

JUN 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 FilmG218 7-18-57 et
5857
CERTIFICATE OF DEATH

05882
21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> COUNTY <u>W.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>W.A. General Hosp.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Lottie</u> Middle <u>B</u> Last <u>Jackson</u>		4. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Approx. <u>79</u> yrs.
9. AGE (In years last birthday) <u>79</u>		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W.A. Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nelson Brown</u>		14. MOTHER'S MAIDEN NAME <u>Lottie Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Frederic Williamson, Severna Park, Md.</u>		Address <u>Severna Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis by fat embolism</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>708.3</u> (b) <u>Thrombotic disease of aorta</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u> <u>neurodermatitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/25/57</u> , 19 <u>57</u> , to <u>6/18/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/18/57</u> , 19 <u>57</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.L. Richardson</u>		ADDRESS (Street, city or town, state) <u>110-CLAY ST ANNAPOLIS, MD.</u>	
DATE SIGNED <u>6/19/57</u>		M.D. <u>110-CLAY ST ANNAPOLIS, MD.</u>	
PHYSICIAN'S NAME (Type) <u>—</u>		DATE SIGNED <u>—</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-23-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Carpenters Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Ground Bay, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Annapolis, Md.</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>JUN 20 1957</u>		DATE <u>—</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

DECEASED

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

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DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

BUREAU V. 3

JUN 21 1957

RECEIVED

5907

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind</i> b. COUNTY <i>A. A.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Barleigh Heights</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Barleigh Heights</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <i>Comer</i> Middle <i>Johnson</i> Last <i>Johnson</i>				4. DATE OF DEATH Month <i>June</i> Day <i>20</i> Year <i>1957</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 16, 1879</i>	9. AGE (In years last birthday) <i>78</i> yrs.	IF UNDER 1 YEAR Months <i>3</i> Days <i>3</i> Hours <i>3</i> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Cambridge Ind</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Charles Banks</i>		Address <i>536 Oxford St</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Tuberculosis</i> <i>204.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>204.4</i> DUE TO (c) <i>204.4</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10-8-56</i> , 19____, to <i>6-20-57</i> , 19____, that I last saw the deceased alive on <i>6-19-57</i> , 19____, and that death occurred at <i>4:55</i> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>A. T. Allen</i> M.D.				ADDRESS (Street, city or town, state) <i>62 Chestnut</i>		DATE SIGNED <i>6-21-57</i>	
PHYSICIAN'S NAME (Type) <i>A. T. ALLEN</i>				<i>Amos A. Johnson</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 23/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Church Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Barleigh Heights Ind</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Amos A. Johnson</i>				ADDRESS <i>Amos A. Johnson</i>		24a. REC'D BY REGISTRAR <i>June 25 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>Amos A. Johnson</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

JUN 25 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05884

5908

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>3yrs.6mos.20days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>931 N. Gay Street</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Edward</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>6</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/21/79</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>Not given</u>				14. MOTHER'S MAIDEN NAME <u>Not given</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u> <u>792x</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>12/31</u> , 19 <u>53</u> , to <u>6/20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/18</u> , 19 <u>57</u> , and that death occurred at <u>5:10p.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ludwig Benedict</u>				ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Ludwig Benedict, M. D.</u>				DATE SIGNED <u>6/21/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. C. Wilson</u>				ADDRESS <u>1000 Brantly Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>6/24/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>K. M. Jones</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	

BUREAU V. S.

JUN 25 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5858

CERTIFICATE OF DEATH

Reg. Dist. No.

05885

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Turkey Point</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. General Hospital</u>		e. STREET ADDRESS <u>Edgewater Md</u>	
3. NAME OF DECEASED (Type or print) <u>3. Garner Jones</u>		4. DATE OF DEATH Month <u>6</u> - Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May-14-1897</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u> Hours <u>57</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salismon</u>	
11. BIRTHPLACE (State or foreign country) <u>Brooms Isle Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joshua Wilson Jones</u>		14. MOTHER'S MAIDEN NAME <u>Edith Elizabeth Garner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war and dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>Grace Ellen Jones</u>	
17. INFORMANT <u>(2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>dissecting Aortic Aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO <u>10 YRS.</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>451x</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/23</u> , 19 <u>57</u> to <u>6/25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/25</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Edward S. Beek</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Edward S. Beek, M. D.</u>		<u>41 Southgate Ave. Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 27-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Skyles</u> ADDRESS <u>U.S. General Hospital</u>		24a. REC'D BY REGISTRAR DATE <u>6/28/57</u>	
24b. REGISTRAR'S SIGNATURE <u>J. J. Council</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5909

Item 2 Film G217 7-5-57 et

CERTIFICATE OF DEATH

05886

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Ann Arundel County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort G. G. Meade</u>				c. LENGTH OF STAY IN 1b <u>Unknown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>US Army Hospital</u>				/ d. STREET ADDRESS <u>Ft G G Meade Maryland</u>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>H.</u> Last <u>Krouse</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>18 April 1933</u>	
9. AGE (In years, low birthday) <u>74</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rector - Sexton Synagogue</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA (nat)</u>	
13. FATHER'S NAME <u>unknw.</u>				14. MOTHER'S MAIDEN NAME <u>Ruth KROOSE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Ruth Mills 817 Jeanette Ave Balt 22, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Previous myocardial infarction</u> DUE TO <u>Cerebrovascular accident.</u> (c) <u>Anterior extension of heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>2 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331x</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2 Jan</u> , 19 <u>57</u> , to <u>29 Jan</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>29 Jan</u> , 19 <u>57</u> , and that death occurred at <u>1040 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>John L. Robertson</u> M.D. <u>2101-1 SUAH F6611, MD 29, 57</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>June 30 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Waldheim</u>		22d. LOCATION (City, town, or county) (State) <u>Chicago Ill</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sam Lawrence</u> ADDRESS <u>W. North Ave 1124-26</u>				24a. REC'D BY REGISTRAR <u>1</u> DATE <u>JUL 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Am. Baylop</u>	

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>a a</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERSTONE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1 MONTH x2 Falesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM ROBERT LEATHERBURY</u>		4. DATE OF DEATH Month Day Year <u>6 21 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 23 1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pilot</u>	
11. BIRTHPLACE (State or foreign country) <u>Shadyside Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WM. Thomas Leatherbury</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN JANE SIMMONS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Robert E. Leatherbury, Falesville Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>502.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>chronic emphysema</u> (c) <u>acute Bronchitis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 10</u> , 19 <u>56</u> to <u>June 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 19</u> , 19 <u>57</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emily H. Wilson</u> M.D.		ADDRESS (Street, city or town, state) <u>Letham, Md.</u> DATE SIGNED <u>6-22-57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Quaker</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Buried Hardisty Salisbury Md</u>		24a. REC'D BY REGISTRAR DATE <u>6/24/57</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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BUREAU V. S.

JUN 27 1951

RECEIVED

5911

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 6mos.13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1011 61st Avenue			
3. NAME OF DECEASED (Type or print) First Ruth Middle Lee Last Lee				4. DATE OF DEATH Month 6 Day 10 Year 19 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/23/94	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 6 Days 10 Hours 19 Min. 57		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) District of Columbia				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME James Bayard				14. MOTHER'S MAIDEN NAME Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrosclerosis with Hypertensive Cardiovascular Disease DUE TO (c) Disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 715X Decubitus ulcers and Anemia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 30		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/30 , 19 56 , to 6/10 , 19 57 , that I last saw the deceased alive on 6/5 , 19 57 , and that death occurred at 10:45a , from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel M. Mapp		ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 6/10/57			
PHYSICIAN'S NAME (Type) Lionel M. Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6/15/57		22c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cem.		22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H.S. Washington & Sons				24. RECORD BY REGISTRAR JUN 14 1957			
ADDRESS 467 N.W. Wash.				24b. REGISTRAR'S SIGNATURE J. M. Joyce			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to the quality of the scan.

BUREAU V. S.

JUN 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05889

5912

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a.a.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>a.a.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Turkey Pt.</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Elizabeth</i> Last <i>Levey</i>		4. DATE OF DEATH Month <i>6</i> - Day <i>19</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 18th 1876</i>
9. AGE (In years last birthday) <i>80</i> yrs.		10. IF UNDER 1 YEAR Months <i>80</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Newton Wells</i>		14. MOTHER'S MAIDEN NAME <i>Susan E. Crandall</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>J. Allan Levey Turkey Pt. Edgewater Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.3</i> DUE TO <i>Cerebral disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Sudden</i> (c) <i>Stroke</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>19</i> Hour <i>0</i> a. m. <i>0</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>6-19-57</i>	
22a. BURIAL CREMATION, or REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-21-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		24a. REC'D BY REGISTRAR <i>424/57</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>J. Daniel</i>	

1
 MARYLAND STATE CERTIFICATE OF HEALTH—BIRTH—AGE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 31

JUN 24 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

21

5913

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Margarets		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt Box 94 Annapolis		d. STREET ADDRESS Rt 2 Box 94	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle LINK Last		4. DATE OF DEATH Month JUNE Day 6 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1886
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Baker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME August Link		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. 419-12-5891A	
17. INFORMANT Mr Melvin Link- Nephew		Address 2200 Eagle St. Baltimore	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lungs DUE TO S Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) With Generalized Metastasis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1st , 1957 , to June 6th , 1957 , that I last saw the deceased alive on June 1st , 1957 , and that death occurred at 7 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gustave H. Faubert, M.D.		ADDRESS (Street, city or town, state) Glen Burnie, Md.	
PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.		DATE SIGNED 6/8/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/10/57	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial	22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		24a. REC'D BY REGISTRAR IN 11 1957	
ADDRESS Annapolis, Md.		24b. REGISTRAR'S SIGNATURE Mr. J. French	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED John Doe		AGE 45		SEX Male		RACE White		DATE OF BIRTH Jan 1, 1912		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE Married		EDUCATION High School		OCCUPATION Teacher		RELIGION Roman Catholic		MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease	
DATE OF DEATH June 10, 1957		PLACE OF DEATH Home		TIME OF DEATH 10:30 AM		TEMPERATURE 101.0		PULSE 100		RESPIRATION 20	
SIGNATURE OF PHYSICIAN J. A. Smith		SIGNATURE OF DECEASED John Doe		SIGNATURE OF WITNESS J. B. Brown		SIGNATURE OF DECEASED John Doe		SIGNATURE OF WITNESS J. B. Brown		SIGNATURE OF DECEASED John Doe	

NAME OF DECEASED John Doe		AGE 45		SEX Male		RACE White		DATE OF BIRTH Jan 1, 1912		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE Married		EDUCATION High School		OCCUPATION Teacher		RELIGION Roman Catholic		MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease	
DATE OF DEATH June 10, 1957		PLACE OF DEATH Home		TIME OF DEATH 10:30 AM		TEMPERATURE 101.0		PULSE 100		RESPIRATION 20	
SIGNATURE OF PHYSICIAN J. A. Smith		SIGNATURE OF DECEASED John Doe		SIGNATURE OF WITNESS J. B. Brown		SIGNATURE OF DECEASED John Doe		SIGNATURE OF WITNESS J. B. Brown		SIGNATURE OF DECEASED John Doe	

BUREAU V. 2

JUN 11 1957

RECEIVED

INSTRUCTIONS

1 **TO ATTEND PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05891

5914

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glen Burnie</u>		LENGTH OF STAY (in this place) <u>10 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glen Burnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>508 Delmar Ave SE</u>				STREET ADDRESS (If rural give location) <u>508 Delmar Ave SE</u>			
3. NAME OF DECEASED (Type or Print) <u>Clara Jane Long</u>				4. DATE OF DEATH (Month) <u>6</u> (Day) <u>18</u> (Year) <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Nov. 5, 1876</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Morris</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs Edith Long, same as 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
157x IMMEDIATE CAUSE (A) <u>Chronic Pulmonary</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JUNE</u> <u>1954</u> , to <u>JUNE</u> <u>1957</u> , that I last saw the deceased alive on <u>6-17</u> <u>1957</u> , and that death occurred at <u>12N</u> <u>M</u> , from the causes and on the date stated above.							
SIGNATURE <u>James McDonald M.D.</u>				ADDRESS (Street, city, town, state) <u>508 Delmar Ave SE</u>		DATE SIGNED <u>6-18-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/21/57</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Baltimore 24</u>	
24. REC'D BY REGISTRAR <u>L. J. Adkins</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>James S. Hopping</u>		ADDRESS <u>Hopping & Kirkley, Glen Burnie</u>	
DATE <u>JUN 20 1957</u>							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1957

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-1-22		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 175	
11. EDUCATION High School		12. RELIGION None		13. PRESENT ADDRESS 308 Del-Mar Ave SE Atlanta, GA 30316		14. PREVIOUS ADDRESS None		15. DATE OF DEATH 6-4-68	
16. CAUSE OF DEATH Suicide		17. MANNER OF DEATH Homicide		18. PLACE OF DEATH Mobile, Ala.		19. TIME OF DEATH 10:00 AM		20. SIGNATURE OF DECEASED None	
21. SIGNATURE OF WITNESS None		22. SIGNATURE OF PHYSICIAN None		23. SIGNATURE OF CORONER None		24. SIGNATURE OF JURY None		25. SIGNATURE OF JUDGE None	

BUREAU V. S.

JUN 20 1957

RECEIVED

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5915

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05892

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1115 E. Audrey Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Plummer Gordon Lowman</u>				4. DATE OF DEATH <u>June 18 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 13, 1888</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMP</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Plummer Lowman</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Lloyd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Glen Lowman</u> Address <u>115 E. Audrey Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thromboses</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arterioscleroses</u> DUE TO (c) <u>Arterioscleroses, Generalized</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u> <u>5-6 years</u> <u>5-6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>450.0</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , 19____, to <u>JUNE 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JUNE 18</u> , 19 <u>57</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Benjamin Berdman</u>				ADDRESS (Street, city or town, state) <u>5010 A Ritchie Hwy</u>			
PHYSICIAN'S NAME (Type) <u>BENJAMIN BERDANN</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUN 21 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN MEM PH</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Jones</u> ADDRESS <u>4801 Ritchie Hwy</u>				24a. REC'D BY REGISTRAR <u>JUN 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Eda Whitson</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John A. Smith</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>June 21, 1957</i>		TIME OF DEATH <i>10:30 AM</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
CAUSE OF DEATH <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>		LOCALITY OF BIRTH <i>Baltimore, Md.</i>	
DATE OF BIRTH <i>May 15, 1912</i>		PLACE OF BIRTH <i>Baltimore, Md.</i>		OCCUPATION <i>Engineer</i>		EDUCATION <i>High School</i>	
MARITAL STATUS <i>Married</i>		SPOUSE'S NAME <i>John A. Smith</i>		SPOUSE'S AGE <i>42</i>		SPOUSE'S OCCUPATION <i>Homemaker</i>	
DECEASED'S SIGNATURE <i>John A. Smith</i>		WITNESS'S SIGNATURE <i>John A. Smith</i>		DECEASED'S ADDRESS <i>1234 Main St.</i>		WITNESS'S ADDRESS <i>1234 Main St.</i>	
DECEASED'S PHONE <i>123-4567</i>		WITNESS'S PHONE <i>123-4567</i>		DECEASED'S RELIGION <i>Catholic</i>		WITNESS'S RELIGION <i>Catholic</i>	
DECEASED'S SOCIAL SECURITY <i>123-456789</i>		WITNESS'S SOCIAL SECURITY <i>123-456789</i>		DECEASED'S MARITAL STATUS <i>Married</i>		WITNESS'S MARITAL STATUS <i>Married</i>	
DECEASED'S OCCUPATION <i>Engineer</i>		WITNESS'S OCCUPATION <i>Engineer</i>		DECEASED'S EDUCATION <i>High School</i>		WITNESS'S EDUCATION <i>High School</i>	
DECEASED'S RACE <i>White</i>		WITNESS'S RACE <i>White</i>		DECEASED'S SEX <i>Male</i>		WITNESS'S SEX <i>Male</i>	
DECEASED'S AGE <i>45</i>		WITNESS'S AGE <i>45</i>		DECEASED'S DATE OF BIRTH <i>May 15, 1912</i>		WITNESS'S DATE OF BIRTH <i>May 15, 1912</i>	
DECEASED'S PLACE OF BIRTH <i>Baltimore, Md.</i>		WITNESS'S PLACE OF BIRTH <i>Baltimore, Md.</i>		DECEASED'S CITY <i>Baltimore</i>		WITNESS'S CITY <i>Baltimore</i>	
DECEASED'S STATE <i>Md.</i>		WITNESS'S STATE <i>Md.</i>		DECEASED'S COUNTRY <i>USA</i>		WITNESS'S COUNTRY <i>USA</i>	
DECEASED'S SIGNATURE <i>John A. Smith</i>		WITNESS'S SIGNATURE <i>John A. Smith</i>		DECEASED'S ADDRESS <i>1234 Main St.</i>		WITNESS'S ADDRESS <i>1234 Main St.</i>	
DECEASED'S PHONE <i>123-4567</i>		WITNESS'S PHONE <i>123-4567</i>		DECEASED'S RELIGION <i>Catholic</i>		WITNESS'S RELIGION <i>Catholic</i>	
DECEASED'S SOCIAL SECURITY <i>123-456789</i>		WITNESS'S SOCIAL SECURITY <i>123-456789</i>		DECEASED'S MARITAL STATUS <i>Married</i>		WITNESS'S MARITAL STATUS <i>Married</i>	
DECEASED'S OCCUPATION <i>Engineer</i>		WITNESS'S OCCUPATION <i>Engineer</i>		DECEASED'S EDUCATION <i>High School</i>		WITNESS'S EDUCATION <i>High School</i>	
DECEASED'S RACE <i>White</i>		WITNESS'S RACE <i>White</i>		DECEASED'S SEX <i>Male</i>		WITNESS'S SEX <i>Male</i>	
DECEASED'S AGE <i>45</i>		WITNESS'S AGE <i>45</i>		DECEASED'S DATE OF BIRTH <i>May 15, 1912</i>		WITNESS'S DATE OF BIRTH <i>May 15, 1912</i>	
DECEASED'S PLACE OF BIRTH <i>Baltimore, Md.</i>		WITNESS'S PLACE OF BIRTH <i>Baltimore, Md.</i>		DECEASED'S CITY <i>Baltimore</i>		WITNESS'S CITY <i>Baltimore</i>	
DECEASED'S STATE <i>Md.</i>		WITNESS'S STATE <i>Md.</i>		DECEASED'S COUNTRY <i>USA</i>		WITNESS'S COUNTRY <i>USA</i>	

BUREAU V. S.

JUN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5859

CERTIFICATE OF DEATH

05893

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1921 Bay Ridge Ave</u>		d. STREET ADDRESS <u>1921 Bay Ridge Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Samuel Tilden MacCubbin</u>		4. DATE OF DEATH <u>June 25 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 23 - 1905</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Instructor Auto Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Instructor</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Samuel T. MacCubbin</u>		14. MOTHER'S MAIDEN NAME <u>Mary Moore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Hazel Welsh MacCubbin</u>	
17. INFORMANT <u>(2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1957</u> , to <u>June 25, 1957</u> , that I last saw the deceased alive on <u>6/20</u> , 1957, and that death occurred at <u>1 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John L. H. H. H.</u> M.D.		ADDRESS (Street, city or town, state) <u>68 Franklin St.</u> DATE SIGNED <u>6/25/57</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>June 28-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louclon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. REC'D BY REGISTRAR <u>6/28/57</u> 24b. REGISTRAR'S SIGNATURE <u>U. D. H.</u>	

RECEIVED

1957 I JUL

BUREAU V. 5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

5916

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05894

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorsey</u>		c. LENGTH OF STAY IN 1b <u>Few seconds</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore-Washington Expressway</u>				d. STREET ADDRESS <u>4801 Sargeant Street, N.E.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sister Adelard McAuliffe, O.S.B.</u>				4. DATE OF DEATH Month Day Year <u>June 3rd, 1957</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nun</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>East Grand Forks, Minn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>823X</u> (a), stating the underlying cause last. DUE TO (c) <u>Sudden</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car skidded off the highway and turned over.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>9:35 A.M. 6/3/57 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route US #8</u>		20f. (City or town) (County) (State) <u>Dorsey, A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6/3/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>O.S.B. Motherhouse Cemetery Duluth, Minn.</u>		22d. LOCATION (City, town, or county) (State) <u>Minn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc. 317 Pa. Ave. S.E.</u>				24a. REC'D BY REGISTRAR <u>6</u>		24b. REGISTRAR'S SIGNATURE <u>Charles H. ...</u>	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU Y. & B.

JUN 6 1957

RECEIVED

Memo from the desk of:

Jim Ryan

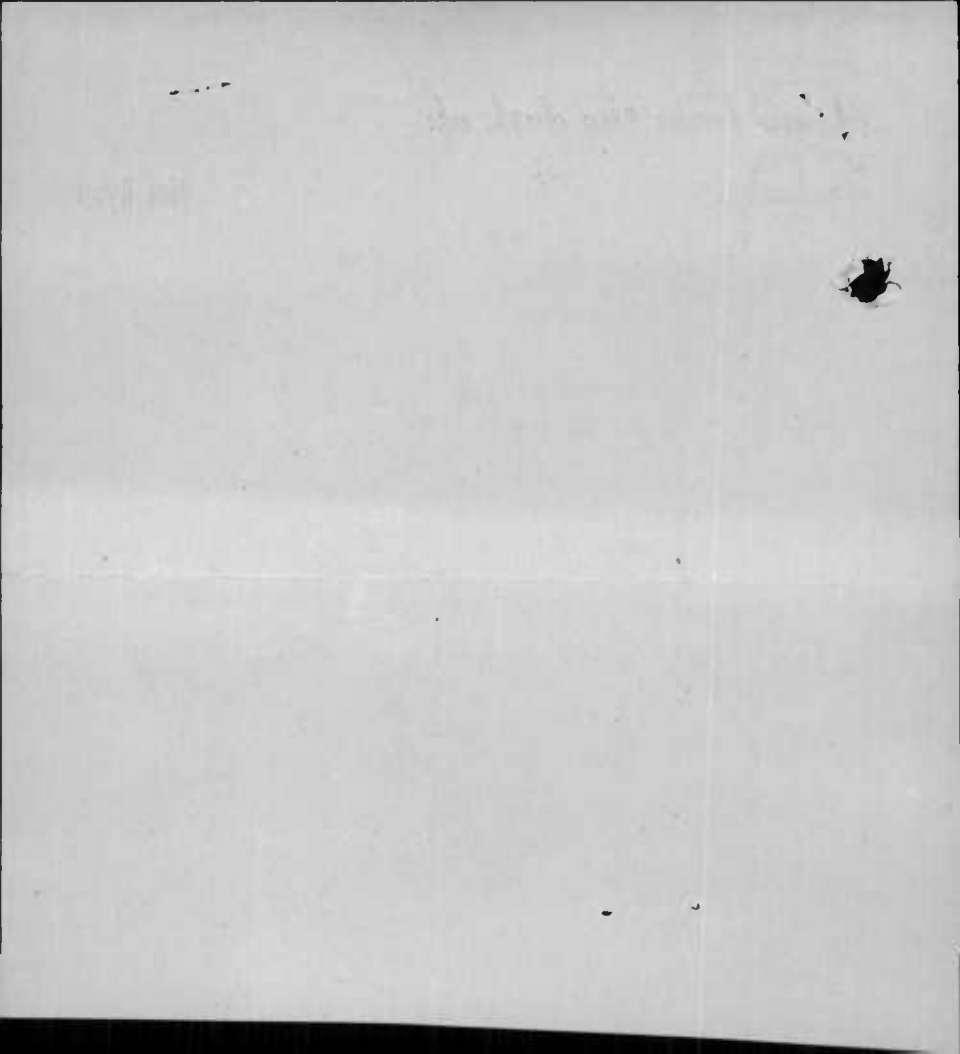
Gentlemen,

We will forward complete
information when possible.

None available in this location.

Sincerely,

Jim Ryan, Jr.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5917 Item 8 Film 4218 7-18-57 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

05895

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 7mos. 24days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				22122			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 514 Delaware Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First William Middle McBride Last McBride				4. DATE OF DEATH Month 6 Day 13 Year 1957			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 9, 1911	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not given				10b. KIND OF BUSINESS OR INDUSTRY Not given		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.				16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Crownsville State Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right cardiac failure 026x DUE TO C. N. S. Syphilis Conditions, if any, which gave rise to immediate case (a), stating the underlying cause last. (b) — DUE TO (c) —				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/20/56 , 19 — , to 6/13 , 19 57 , that I last saw the deceased alive on 6/13 , 19 57 , and that death occurred at 10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ludwig Benedict				ADDRESS (Street, city or town, state) Crownsville, Md.			
DATE SIGNED 6/14/57							
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial				22b. DATE THEREOF June 17, 57		22c. NAME OF CEMETERY OR CREMATORY Deer Island Cem	
22d. LOCATION (City, town, or county) (State) Deer Island Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Booker M. West				ADDRESS —		24a. REC'D BY REGISTRAR JUN 17 1957	
24b. REGISTRAR'S SIGNATURE J. M. Jones							

CERTIFICATE OF DEATH

<p>NAME OF DECEASED JAMES S. BOWEN</p>		<p>AGE 68</p>	
<p>DATE OF DEATH JUNE 17, 1957</p>		<p>PLACE OF DEATH HOME</p>	
<p>CAUSE OF DEATH HEART DISEASE</p>		<p>IMMEDIATE CAUSE HEART ATTACK</p>	
<p>DATE OF BIRTH JANUARY 1, 1889</p>		<p>PLACE OF BIRTH BALTIMORE, MD</p>	
<p>SEX MALE</p>		<p>RACE WHITE</p>	
<p>EDUCATION HIGH SCHOOL</p>		<p>OCCUPATION RETIRED</p>	
<p>RELIGION METHODIST</p>		<p>USUAL RESIDENCE 1111 N. W. 10th St.</p>	
<p>DATE OF DEATH JUNE 17, 1957</p>		<p>TIME OF DEATH 10:30 AM</p>	
<p>PLACE OF DEATH HOME</p>		<p>DATE OF DEATH JUNE 17, 1957</p>	
<p>CAUSE OF DEATH HEART DISEASE</p>		<p>IMMEDIATE CAUSE HEART ATTACK</p>	
<p>DATE OF BIRTH JANUARY 1, 1889</p>		<p>PLACE OF BIRTH BALTIMORE, MD</p>	
<p>SEX MALE</p>		<p>RACE WHITE</p>	
<p>EDUCATION HIGH SCHOOL</p>		<p>OCCUPATION RETIRED</p>	
<p>RELIGION METHODIST</p>		<p>USUAL RESIDENCE 1111 N. W. 10th St.</p>	
<p>DATE OF DEATH JUNE 17, 1957</p>		<p>TIME OF DEATH 10:30 AM</p>	
<p>PLACE OF DEATH HOME</p>		<p>DATE OF DEATH JUNE 17, 1957</p>	
<p>CAUSE OF DEATH HEART DISEASE</p>		<p>IMMEDIATE CAUSE HEART ATTACK</p>	

BUREAU V. 5

JUN 17 1957

RECEIVED

VS. A15ME(5)
5M 9/55

05896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Arundel</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn 50</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pond, branch of Potapasco River</u>		d. STREET ADDRESS <u>16 Pebble Drive, Lukes Trailer Camp.</u>	
3. NAME OF DECEASED (Type or print) <u>Stanley Leon McCauley</u>		4. DATE OF DEATH <u>June 19th.</u>	
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>6/1/47</u>	
9. AGE (In years last birthday) <u>10 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pupil</u>	
11. BIRTHPLACE (State or foreign country) <u>Mill Creek, West Virginia.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Olan Stanley McCauley</u>		14. MOTHER'S MAIDEN NAME <u>Nettie McCauley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. 	
17. INFORMANT <u>Mr. Olan McCauley, Father.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>Accidental Drowning</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Drowning</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		22. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gustave H. Faubert, M.D.</u>		24. REC'D BY REGISTRAR <u>6/15/57</u>	
25. BURIAL, CREMATION, REMOVAL (Specify) <u>6-17-57</u>		26. NAME OF CEMETERY OR CREMATORY <u>CECAL Hill</u>	
27. ADDRESS <u>16 Pebble Drive, Lukes Trailer Camp.</u>		28. REGISTRAR'S SIGNATURE <u>6/15/57</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUN 17 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05897

5860

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>32 BLOOMSBURY Sq.</u>		d. STREET ADDRESS <u>32 BLOOMSBURY</u>	
3. NAME OF DECEASED (Type or print) First <u>NEBBIE</u> Middle <u>E</u> Last <u>MEEKINS</u>		4. DATE OF DEATH Month <u>6</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-2-1884</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN H. COLE</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE C. Austin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>William W. MEEKINS</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>422.2</u> DUE TO (b) <u>Heart Block</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cor. Myocarditis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>433.0</u> INTERVAL BETWEEN ONSET AND DEATH <u>about 36 hrs</u> <u>Some months</u> <u>Some months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 21, 1957</u> , to <u>June 21, 1957</u> , that I last saw the deceased alive on <u>June 21, 1957</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Oliver Purvis</u>		ADDRESS (Street, city or town, state) <u>40 Franklin St. Annapolis, Md.</u>	
NAME (Type) <u>J. OLIVER PURVIS</u>		DATE SIGNED <u>ANNAPOLIS, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-23-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		24a. REC'D BY REGISTRAR <u>6/24/57</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

CERTIFICATE OF DEATH

5880

NAME OF DECEASED <i>John Doe</i>		SEX <i>Male</i>		AGE <i>45</i>		DATE OF BIRTH <i>Jan 15 1912</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>		RACE <i>White</i>		RELIGION <i>Catholic</i>		MARRIAGE <i>Married</i>		EDUCATION <i>High School</i>		OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DATE OF DEATH <i>June 25 1957</i>		PLACE OF DEATH <i>Home</i>		SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF PHYSICIAN <i>John Doe</i>		SIGNATURE OF CORONER <i>John Doe</i>		SIGNATURE OF BURIAL OFFICER <i>John Doe</i>		SIGNATURE OF MINISTER <i>John Doe</i>		SIGNATURE OF OTHER <i>John Doe</i>	
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BUREAU V. S.

JUN 25 1957

RECEIVED

NAME OF DECEASED <i>John Doe</i>		SEX <i>Male</i>		AGE <i>45</i>		DATE OF BIRTH <i>Jan 15 1912</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>		RACE <i>White</i>		RELIGION <i>Catholic</i>		MARRIAGE <i>Married</i>		EDUCATION <i>High School</i>		OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DATE OF DEATH <i>June 25 1957</i>		PLACE OF DEATH <i>Home</i>		SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF PHYSICIAN <i>John Doe</i>		SIGNATURE OF CORONER <i>John Doe</i>		SIGNATURE OF BURIAL OFFICER <i>John Doe</i>		SIGNATURE OF MINISTER <i>John Doe</i>		SIGNATURE OF OTHER <i>John Doe</i>	
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5919

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05898

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Orchard Beach

c. LENGTH OF STAY IN 1b

2 hrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Stoney Creek

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

A.A.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore

d. STREET ADDRESS

2460 Nevada St. (2460 Nevada St.)

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

Middle

Last

Edward Barnes Miller

4. DATE OF DEATH

Month

Day

Year

June 23rd.

1957

5. SEX

M.

6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

11/9/42

9. AGE (in years last birthday)

14 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Attending School

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry M. Miller

14. MOTHER'S MAIDEN NAME

Gertrude Dorothy Ferber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mr. Harry M. Miller, (Father)

2460 Nevada Street, Westport

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Accidental Browning

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH
Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Drowning (could not swim)

20c. TIME OF INJURY

Month, Day, Year

Hour a. m.

p. m.

6/23/57

19

20d. INJURY OCCURRED

While of work ☐ Not while of work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Stoney Creek

20f. (City or town)

Orchard Beach

(County)

A.A.

(State)

Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE

Gustave H. Faubert, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

June 24th. 1957.

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

6-27-57

22c. NAME OF CEMETERY OR CREMATORY

Baltimore, Cemetery

22d. LOCATION (City, town, or county)

East North Ave. Balto: Md.

23. FUNERAL DIRECTOR'S SIGNATURE

George J. Ruth, Inc. - 1735 Harford Avenue
Balto: Md.

ADDRESS

24. RECEIVED BY REGISTRAR

DATE

JUN 26 1957

25. REGISTRAR'S SIGNATURE

L. J. Kelly

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
JUN 26 1957
BUREAU V. S.

See letter to Bureau dated 6/26/57

George J. ... Inc. 1735 ...
Baltimore, Maryland

5861

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 906 Ridgeway Ave.	
3. NAME OF DECEASED (Type or print) First Thelma Middle F. Last O'Neale		4. DATE OF DEATH Month June Day 17 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1902
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James L. Taylor	
14. MOTHER'S MAIDEN NAME Jenny Morrisberger		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mr Eugene L. O'Neale - Husband- same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Congestive Failure 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 422.1 (b) Arteriosclerosis CVD DUE TO (c) Diabetes M.			INTERVAL BETWEEN ONSET AND DEATH 4 hrs. yes.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sanguine, left foot & leg, amputated			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street
20f. (City or town) Elkton, Maryland		20g. (County) (State)	
21. I certify that I attended the deceased from 12-22-1952 to 6-17-1957 , that I last saw the deceased alive on 6-17-1957 , and that death occurred at 9:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank M. Shipley M.D.		ADDRESS (Street, city or town, state) 63 College Ave. Annapolis, Md.	
PHYSICIAN'S NAME (Type) Frank Shipley		DATE SIGNED 6-18-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 21 1957	22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	22d. LOCATION (City, town, or county) (State) Elkton, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR JUN 20 1957		24b. REGISTRAR'S SIGNATURE Wm. J. French	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

1957

1. Name of deceased: *James H. [illegible]*
 2. Date of death: *June 17, 1957*
 3. Place of death: *Home*

4. Age at death: *68*
 5. Sex: *Male*
 6. Race: *White*

7. Cause of death: *Heart disease*
 8. Immediate cause: *Myocardial infarction*

9. Duration of illness: *2 weeks*
 10. Date of birth: *June 17, 1889*

11. Place of birth: *St. Louis, Mo.*
 12. Date of marriage: *June 17, 1917*

13. Name of spouse: *Elizabeth [illegible]*
 14. Name of father: *John [illegible]*

15. Name of mother: *Mary [illegible]*
 16. Date of death of father: *June 17, 1947*

17. Date of death of mother: *June 17, 1947*
 18. Name of informant: *James H. [illegible]*

19. Signature of informant: *[Signature]*
 20. Date of completion: *June 17, 1957*

21. Signature of registrar: *[Signature]*
 22. Date of registration: *June 17, 1957*

23. Signature of physician: *[Signature]*
 24. Date of completion: *June 17, 1957*

25. Signature of coroner: *[Signature]*
 26. Date of completion: *June 17, 1957*

27. Signature of funeral director: *[Signature]*
 28. Date of completion: *June 17, 1957*

29. Signature of cemetery: *[Signature]*
 30. Date of completion: *June 17, 1957*

31. Signature of burial society: *[Signature]*
 32. Date of completion: *June 17, 1957*

33. Signature of interment: *[Signature]*
 34. Date of completion: *June 17, 1957*

35. Signature of cremation: *[Signature]*
 36. Date of completion: *June 17, 1957*

37. Signature of other: *[Signature]*
 38. Date of completion: *June 17, 1957*

39. Signature of other: *[Signature]*
 40. Date of completion: *June 17, 1957*

41. Signature of other: *[Signature]*
 42. Date of completion: *June 17, 1957*

43. Signature of other: *[Signature]*
 44. Date of completion: *June 17, 1957*

45. Signature of other: *[Signature]*
 46. Date of completion: *June 17, 1957*

47. Signature of other: *[Signature]*
 48. Date of completion: *June 17, 1957*

49. Signature of other: *[Signature]*
 50. Date of completion: *June 17, 1957*

51. Signature of other: *[Signature]*
 52. Date of completion: *June 17, 1957*

53. Signature of other: *[Signature]*
 54. Date of completion: *June 17, 1957*

RECEIVED
 JUN 20 1957
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5862

CERTIFICATE OF DEATH

Reg. Dist. No.

0590021

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>C.D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. C. General Hosp.</u>				d. STREET ADDRESS <u>1805 St. Washington</u>			
3. NAME OF DECEASED (Type or print) <u>Carrie C. Parker</u>				4. DATE OF DEATH <u>6</u> <u>18</u> <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-3-1884</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Nelson Mc Gowans</u>			
14. MOTHER'S MAIDEN NAME <u>Manly M. Crowley</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Huby Brown - Anna. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho - Pneumonia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Hemorrhage</u> DUE TO <u>Arterio-sclerotic Hypertensive Cardiovascular disease</u> <u>331X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>5/20/1957</u> to <u>6/18/1957</u> , that I last saw the deceased alive on <u>6/18/57</u> , 19 <u>57</u> , and that death occurred at <u>1100</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Richardson</u>				ADDRESS (Street, city or town, state) <u>110 - CHAY ST ANNAPOLIS, MD.</u>			
DATE SIGNED <u>6/19/57</u>				22. PHYSICIAN'S NAME (Type) <u>William Reese, Jr - Anna. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>6-23-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>Wm. J. Funch</u>				24b. REGISTRAR'S SIGNATURE <u>Wm. J. Funch</u>			

BUREAU V. S.

JUN 21 1957

RECEIVED

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5863

CERTIFICATE OF DEATH

05901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>W.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General Hosp.</u>		d. STREET ADDRESS <u>125 Monument St.</u>	
3. NAME OF DECEASED (Type or print) <u>Lillie</u> First <u>Barker</u> Middle <u>Barber</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Charles Davis</u>		14. MOTHER'S MAIDEN NAME <u>Mary Lee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>Mary E. Davis - Annapolis, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>_____</u> DUE TO (c) <u>_____</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>_____</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. j. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-11-57</u> 19, to <u>6-16-57</u> 19, that I last saw the deceased alive on <u>6-16-57</u> 19, and that death occurred at <u>10:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.T. Allen</u> M.D.		DATE SIGNED <u>6-19-57</u>	
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6-19-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>		ADDRESS <u>_____</u>	
24a. REC'D BY REGISTRAR <u>_____</u> DATE <u>20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>_____</u>	

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

Reg. Dist. No.

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JUN 21 1957
BUREAU V. 2

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5864

CERTIFICATE OF DEATH

Reg. Dist. No.

05902

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>South River Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Allen Roy Peake</u>		4. DATE OF DEATH <u>6-7-1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. Date of birth <u>10-6-1888</u> 9. Age <u>68</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumber</u>	
11. BIRTHPLACE (State or foreign country) <u>A. A. Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Millard E. Peake</u>		14. MOTHER'S MAIDEN NAME <u>Emma Cole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>181X</u>	
17. INFORMANT <u>Joseph R. Peake</u>		Address <u>Riva Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>carcinoma of bladder</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>50</u> to <u>June 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 7</u> , 19 <u>57</u> , and that death occurred at <u>2:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Borssuck</u>		ADDRESS (Street, city or town, state) <u>Amos Garrett Blvd.</u>	
PHYSICIAN'S NAME (Type) <u>S. Borssuck, M.D.</u>		DATE SIGNED <u>6/10/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-10-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Quaker Burial Grounds</u>	22d. LOCATION (City, town, or county) (State) <u>West River Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u>		24a. REC'D BY REGISTRAR <u>6/10/57</u> 24b. REGISTRAR'S SIGNATURE <u>J. Saylor</u>	

5865

CERTIFICATE OF DEATH

05903

Reg. Dist. No. 21

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waterbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>C.C. General Hosp.</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Queen</u> Last <u>Queen</u>		4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-1-1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Queen</u>		14. MOTHER'S MAIDEN NAME <u>Salie Dugge</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Shelton Queen - Waterbury, Md.</u>	
17. INFORMANT <u>Shelton Queen - Waterbury, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis R middle cerebral artery</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Fast</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X Terminal bronchopneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/18</u> , 19 <u>57</u> , to <u>6/24</u> , 19 <u>57</u> , that I lost saw the deceased olive on <u>6/23</u> , 19 <u>57</u> , and that death occurred at <u>40</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Hildebrand</u> M.D.		ADDRESS (Street, city or town, state) <u>68 Franklin St. - Annapolis, Md.</u>	
DATE SIGNED <u>6/25/57</u>			
PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-26-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	22d. LOCATION (City, town, or county) (State) <u>Waterbury, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Annapolis, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DATE 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John J. Lynch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, with

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5866

CERTIFICATE OF DEATH

Reg. Dist. No.

05904

1. PLACE OF DEATH a. COUNTY <u>Q. Q.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q. Q.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. General Hospital</u>		d. STREET ADDRESS <u>1112 Eastport Terrace</u>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>E.</u> Last <u>Racey</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-1908</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edwin S. Hager</u>		14. MOTHER'S MAIDEN NAME <u>Effie M. Melburn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>5200 911 S.E.</u>	
17. INFORMATION <u>Leroy P. Hager</u>		18. ADDRESS <u>Washington 27 D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia ;</u> DUE TO (b) <u>arteriosclerotic cardio-vascular</u> DUE TO (c) <u>renal disease c ;hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days.</u> 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>576X localized peritonitis (cause not determined)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/18/57</u> , 19 <u>6/25/57</u> , that I last saw the deceased alive on <u>6/25/57</u> , 19 <u>6/25/57</u> , and that death occurred at <u>11:30 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Amos Garrett Blvd.</u> DATE SIGNED <u>6/28/57</u> ACTUAL SIGNATURE <u>S. Borssuck</u> M.D. PHYSICIAN'S NAME (Type) <u>S. Borssuck, M.D.</u> <u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6-28-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cent</u>	22d. LOCATION (City, town, county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor, Sons</u>		24a. REC'D BY REGISTRAR <u>6/28/57</u>	24b. REGISTRAR'S SIGNATURE <u>J. W. Taylor</u>

BUREAU V. 8

1957 3 77

RECEIVED

5920

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>B.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>226 Arden Road</u>		d. STREET ADDRESS <u>226 Arden Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Estie</u> Middle <u>Ragan</u> Last <u>Ragan</u>		4. DATE OF DEATH June 13 1957	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1897
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob Strupp</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Pigger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Joseph P. Peller 629 Aldershot Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insufficiency</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-8</u> , 19 <u>53</u> , to <u>6-18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-13</u> , 19 <u>57</u> , and that death occurred at <u>8 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eugene Schmitzer</u> M.D.		ADDRESS (Street, city or town, state) <u>3904 S. HANOVER ST.</u> DATE SIGNED <u>JUN 17 1957</u>	
PHYSICIAN'S NAME (Type) <u>Eugene Schmitzer M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		22b. DATE THEREOF <u>6-18-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brooklyn Park</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn Park</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Bowan</u> ADDRESS <u>401 Hollister St</u>		24a. REC'D BY REGISTRAR <u>Eda Hinton</u> 24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3.

JUN 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5867

CERTIFICATE OF DEATH

05906

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hosp. Annapolis, Md.</u>				d. STREET ADDRESS <u>1010 Jackson Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Rudolf</u> Last <u>RAYHART</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>5</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-27-83</u>	
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LT USN RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>USN</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Emery (n) RAYHART</u>				14. MOTHER'S MAIDEN NAME <u>Helen (n) BABOT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1908-1937</u>		17. INFORMANT <u>U.S. Naval Hospital, Annapolis, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (d).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, squamous - cell, metastatic</u> <u>161X</u> DUE TO (b) <u>(Primary cite larynx)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Extreme Cachexia</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4 June</u> , 19 <u>57</u> , to <u>5 June</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5 June</u> , 19 <u>57</u> , and that death occurred at <u>2:50 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U. S. Naval Hospital, Annapolis, Md.</u> DATE SIGNED <u>5 June 1957</u> ACTUAL SIGNATURE <u>Luis A. Morales</u> M.D. <u>U. S. Naval Hospital, Annapolis, Md.</u> PHYSICIAN'S NAME (Type) <u>Luis A. MORALES</u> <u>LCDR MC USNR</u> <u>5 June 1957</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 7, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE 7 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Am. J. Funch</u>	

CERTIFICATE OF DEATH

<p>1. Name of deceased: JOHN J. BROWN</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: 1901-01-01</p>		<p>4. Place of birth: New York</p>	
<p>5. Date of death: 1957-06-02</p>		<p>6. Place of death: New York</p>	
<p>7. Cause of death: Heart Disease</p>		<p>8. Manner of death: Natural</p>	
<p>9. Signature of physician: Dr. J. J. Smith</p>		<p>10. Signature of registrar: John J. Brown</p>	
<p>11. Date of registration: 1957-06-02</p>		<p>12. Place of registration: New York</p>	
<p>13. Signature of registrar: John J. Brown</p>		<p>14. Signature of registrar: John J. Brown</p>	
<p>15. Signature of registrar: John J. Brown</p>		<p>16. Signature of registrar: John J. Brown</p>	
<p>17. Signature of registrar: John J. Brown</p>		<p>18. Signature of registrar: John J. Brown</p>	
<p>19. Signature of registrar: John J. Brown</p>		<p>20. Signature of registrar: John J. Brown</p>	
<p>21. Signature of registrar: John J. Brown</p>		<p>22. Signature of registrar: John J. Brown</p>	
<p>23. Signature of registrar: John J. Brown</p>		<p>24. Signature of registrar: John J. Brown</p>	
<p>25. Signature of registrar: John J. Brown</p>		<p>26. Signature of registrar: John J. Brown</p>	
<p>27. Signature of registrar: John J. Brown</p>		<p>28. Signature of registrar: John J. Brown</p>	
<p>29. Signature of registrar: John J. Brown</p>		<p>30. Signature of registrar: John J. Brown</p>	
<p>31. Signature of registrar: John J. Brown</p>		<p>32. Signature of registrar: John J. Brown</p>	
<p>33. Signature of registrar: John J. Brown</p>		<p>34. Signature of registrar: John J. Brown</p>	
<p>35. Signature of registrar: John J. Brown</p>		<p>36. Signature of registrar: John J. Brown</p>	
<p>37. Signature of registrar: John J. Brown</p>		<p>38. Signature of registrar: John J. Brown</p>	
<p>39. Signature of registrar: John J. Brown</p>		<p>40. Signature of registrar: John J. Brown</p>	
<p>41. Signature of registrar: John J. Brown</p>		<p>42. Signature of registrar: John J. Brown</p>	
<p>43. Signature of registrar: John J. Brown</p>		<p>44. Signature of registrar: John J. Brown</p>	
<p>45. Signature of registrar: John J. Brown</p>		<p>46. Signature of registrar: John J. Brown</p>	
<p>47. Signature of registrar: John J. Brown</p>		<p>48. Signature of registrar: John J. Brown</p>	
<p>49. Signature of registrar: John J. Brown</p>		<p>50. Signature of registrar: John J. Brown</p>	
<p>51. Signature of registrar: John J. Brown</p>		<p>52. Signature of registrar: John J. Brown</p>	
<p>53. Signature of registrar: John J. Brown</p>		<p>54. Signature of registrar: John J. Brown</p>	
<p>55. Signature of registrar: John J. Brown</p>		<p>56. Signature of registrar: John J. Brown</p>	
<p>57. Signature of registrar: John J. Brown</p>		<p>58. Signature of registrar: John J. Brown</p>	
<p>59. Signature of registrar: John J. Brown</p>		<p>60. Signature of registrar: John J. Brown</p>	
<p>61. Signature of registrar: John J. Brown</p>		<p>62. Signature of registrar: John J. Brown</p>	
<p>63. Signature of registrar: John J. Brown</p>		<p>64. Signature of registrar: John J. Brown</p>	
<p>65. Signature of registrar: John J. Brown</p>		<p>66. Signature of registrar: John J. Brown</p>	
<p>67. Signature of registrar: John J. Brown</p>		<p>68. Signature of registrar: John J. Brown</p>	
<p>69. Signature of registrar: John J. Brown</p>		<p>70. Signature of registrar: John J. Brown</p>	
<p>71. Signature of registrar: John J. Brown</p>		<p>72. Signature of registrar: John J. Brown</p>	
<p>73. Signature of registrar: John J. Brown</p>		<p>74. Signature of registrar: John J. Brown</p>	
<p>75. Signature of registrar: John J. Brown</p>		<p>76. Signature of registrar: John J. Brown</p>	
<p>77. Signature of registrar: John J. Brown</p>		<p>78. Signature of registrar: John J. Brown</p>	
<p>79. Signature of registrar: John J. Brown</p>		<p>80. Signature of registrar: John J. Brown</p>	
<p>81. Signature of registrar: John J. Brown</p>		<p>82. Signature of registrar: John J. Brown</p>	
<p>83. Signature of registrar: John J. Brown</p>		<p>84. Signature of registrar: John J. Brown</p>	
<p>85. Signature of registrar: John J. Brown</p>		<p>86. Signature of registrar: John J. Brown</p>	
<p>87. Signature of registrar: John J. Brown</p>		<p>88. Signature of registrar: John J. Brown</p>	
<p>89. Signature of registrar: John J. Brown</p>		<p>90. Signature of registrar: John J. Brown</p>	
<p>91. Signature of registrar: John J. Brown</p>		<p>92. Signature of registrar: John J. Brown</p>	
<p>93. Signature of registrar: John J. Brown</p>		<p>94. Signature of registrar: John J. Brown</p>	
<p>95. Signature of registrar: John J. Brown</p>		<p>96. Signature of registrar: John J. Brown</p>	
<p>97. Signature of registrar: John J. Brown</p>		<p>98. Signature of registrar: John J. Brown</p>	
<p>99. Signature of registrar: John J. Brown</p>		<p>100. Signature of registrar: John J. Brown</p>	

BUREAU V. 3

JUN 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5868

CERTIFICATE OF DEATH

05907

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 46 Southgate Ave.				d. STREET ADDRESS 46 Southgate Ave.			
3. NAME OF DECEASED (Type or print) First HARRY Middle A Last REICHEL				4. DATE OF DEATH Month JUNE Day 19 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 6, 1902 1901	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY U S Gov.		11. BIRTHPLACE (State or foreign country) New York City	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Hyman Reichel				14. MOTHER'S MAIDEN NAME Lena R. Reichel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs Lena Reichel -- Wife- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease? DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1						INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19 56 to April 19 57 , that I last saw the deceased alive on June 5 19 57 , and that death occurred at 7:00 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 31 Southgate Ave. Annapolis, Md. DATE SIGNED June 20 1957							
ACTUAL SIGNATURE Maurice F. Klawans M.D.							
PHYSICIAN'S NAME (Type) Maurice F. Klawans				31 Southgate Ave. Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-20-57		22c. NAME OF CEMETERY OR CREMATORY Kneseth Israel Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Maryland				24a. REC'D BY REGISTRAR Don J. French DATE JUN 20 1957			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12. *Journal of the American Medical Association*, 1997; 278: 1039-1044.

BUREAU V.

JUN 20 1957

RECEIVED

5921
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastport, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastport, Md</u> X 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>111 Eastern Ave</u>		d. STREET ADDRESS <u>6 111 Eastern Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Levie</u> <u>Robinson</u>		4. DATE OF DEATH Month Day Year <u>June</u> <u>28</u> <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Harnett</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Adell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>1817 Eastern Pl.</u>	
17. INFORMANT <u>Dr. Aaron Robinson</u>		Address <u>1817 Eastern Pl.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 28</u> , 19 <u>57</u> , to <u>July 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 28</u> , 19 <u>57</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. L. IN HART</u>		DATE SIGNED <u>6/28/57</u>	
PHYSICIAN'S NAME (Type) <u>E. L. IN HART</u>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 30/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Maac Israel</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Levine</u>		24a. REC'D BY REGISTRAR <u>1</u>	
24b. REGISTRAR'S SIGNATURE <u>1134-26</u>		24c. REGISTRAR'S SIGNATURE <u>1134-26</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Form D-1, Rev. 1-55

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]	
6. MARITAL STATUS [Faint text]		7. OCCUPATION [Faint text]		8. CAUSE OF DEATH [Faint text]		9. MANNER OF DEATH [Faint text]		10. PLACE OF DEATH [Faint text]	
11. SIGNATURE OF DECEASED [Faint text]		12. SIGNATURE OF WITNESS [Faint text]		13. SIGNATURE OF PHYSICIAN [Faint text]		14. SIGNATURE OF CORONER [Faint text]		15. SIGNATURE OF JURY [Faint text]	

BUREAU V. S.

JUL 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05909

5922

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crowsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crowsville State Hospital</u>		d. STREET ADDRESS <u>27 Spring Street</u>	
3. NAME OF DECEASED (Type or print) <u>Susie Robinson</u>		4. DATE OF DEATH <u>June 9 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Not given</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not given</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ben Powell</u>		14. MOTHER'S MAIDEN NAME <u>Julia Fipps</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Not given</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Crowsville State Hospital Crowsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>171X Cancer of cervix with metastasis</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 23</u> , 19 <u>56</u> , to <u>June 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 9, 1957</u> at <u>11:55 AM</u> , and that death occurred at <u>11:55 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ludwig Benedict</u>		ADDRESS (Street, city or town, state) <u>Crowsville, Md.</u> DATE SIGNED <u>6/10/57</u>	
PHYSICIAN'S NAME (Type) <u>Ludwig Benedict, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>		22b. DATE THEREOF <u>6-12-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Not given</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese - Anna. Md.</u>		24a. REC'D BY REGISTRAR <u>June 17 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>H. M. Jones</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 3

JUN 18 1957

RECEIVED

5923

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY A.A. County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Linthicum		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Linthicum	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 21 Hampton Road		d. STREET ADDRESS 21 Hampton Road	
3. NAME OF DECEASED (Type or print) First Charles Middle J.H. Last Roos, Sr.		4. DATE OF DEATH Month June Day 16 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 26, 1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher (Ret'd)		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles J.H. Roos, Jr.,		Address North Linthicum	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intussusception C.V.D. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1		INTERVAL BETWEEN ONSET AND DEATH 54 hrs 54 hrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19 50 to June 19 57 , that I last saw the deceased alive on June 1 , 19 57 , and that death occurred on June 16 , 19 57 , from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul Schonfeld M.D.		ADDRESS (Street, city or town, state) 2301 Annapolis Rd DATE SIGNED 6/18/57	
PHYSICIAN'S NAME (Type) Paul Schonfeld		2301 Annapolis Rd	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-19-57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Rithie Highway
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR JUN 19 57 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5.

JUN 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5924 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05911

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cape St. Claire, P.O. Annapolis</u> c. LENGTH OF STAY IN 1b <u>15 minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magothy River</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>35014</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1449 Hull St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>William Edward Ross</u> First Middle Last				4. DATE OF DEATH <u>May June 2nd.</u> 19 <u>57</u> Month Day Year															
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/3/40</u>		9. AGE (In years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper in a grocery store.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>				11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Ross</u>				14. MOTHER'S MAIDEN NAME <u>Eileen Schultz</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Mrs. William Ross (mother)</u>				17. INFORMANT <u>1449 HULL ST.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> <u>850X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>(a), stating the underlying cause last.</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Jumped in the water from a rowboat and could not swim.</u>															
20c. TIME OF INJURY Month, Day, Year <u>2:15 P.M. 6/2/57</u> 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Magothy River</u>		20f. (City or town) <u>Cape St. Claire, A.A.</u>		(County) <u>Md.</u>		(State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>6/2/57</u>											
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>JUNE 6, 1967</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN CEMETERY</u>				22d. LOCATION (City, town, or county) <u>ANNE ARUNDEL MD.</u> (State)									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. [Signature]</u>						ADDRESS <u>1501 E. Fort Ave</u>		24a. REC'D BY REGISTRAR <u>1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUN 6 1957

BUREAU V. 2

5925

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena, Md.</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Marie</u> Last <u>Ruppel</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6, 1893</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tavern Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>	
11. BIRTHPLACE (State or foreign country) <u>Winfield, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward M. Zile</u>		14. MOTHER'S MAIDEN NAME <u>Emma Bowers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>214-38-7211</u>	
17. INFORMANT <u>Emma Elseroad, Pasadena, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia (blockage of both ureters)</u> <u>154X</u> DUE TO (b) <u>Metastasis</u> DUE TO (c) <u>Carcinoma of the recto-sigmoid</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>?</u> <u>1 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>56</u> , to <u>May 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 5</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>900 Remondstown Rd - 6/7/57</u>			
ACTUAL SIGNATURE <u>Grace G. Jones, M.D.</u>		M.D. <u>900 Remondstown Rd - 6/7/57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Grace G. Jones</u>		<u>Baltimore 8 - Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 8, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville 8, Md.</u>		ADDRESS <u>Pikesville 8, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUN 10 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Hall</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

1957

DATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

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BUREAU V. S.

JUN 10 1957

RECEIVED

1
5869 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05913

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A. A. G. Ben. Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Randolph</i> Middle <i>Russell</i> Last <i>Russell</i>		4. DATE OF DEATH Month <i>June</i> Day <i>12</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 23 1908</i>
9. AGE (In years last birthday) <i>49</i> yrs.		IF UNDER 1 YEAR Months <i>8</i> Days <i>12</i>	IF UNDER 24 HRS. Hours <i>19</i> Min. <i>57</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Submariner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>City Employee</i>	
11. BIRTHPLACE (State or foreign country) <i>Calvert, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Randolph Russell Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Mary unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>2 11-05-1848</i>	
17. INFORMANT <i>Anna Mary Russell, Annapolis</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart disease</i> DUE TO (b) <i>434.9</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. L. Lohardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. L. Lohardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>6/12/57</i>	
22a. FUNERAL CREMATION, REMOVAL (Specify) <i>Funeral</i>		22b. DATE THEREOF <i>June 10/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Brown Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Annie A. Johnson</i>		ADDRESS <i>Annapolis</i>	
24a. REC'D BY REGISTRAR <i>June 18 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. J. French</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JUN 18 1957

5926

CERTIFICATE OF DEATH

059147

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>XO Riviera Beach</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Larson Nursing Home</i>		d. STREET ADDRESS <i>1 Crundel and Bay Roads</i>	
3. NAME OF DECEASED (Type or print) First <i>JOHN</i> Middle <i>FRED</i> Last <i>SCHMIDT</i>		4. DATE OF DEATH Month <i>JUNE</i> Day <i>11</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 30-1869</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chamber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	11. BIRTHPLACE (State or foreign country) <i>M.D.</i>
13. FATHER'S NAME <i>Gustord Schmidt</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Rhinehart</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-24-7075</i>	
17. INFORMANT <i>Mrs. Sarah E. Schmidt</i>		Address <i>Riviera Beach</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c) <i>450.0</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i> <i>5 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>450.0</i>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10/30</i> , 1953, to <i>6/11</i> , 1957, that I last saw the deceased alive on <i>6/11</i> , 1957, and that death occurred at <i>8:15 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Brady Smith</i> M.D.		ADDRESS (Street, city or town, state) <i>Riviera Beach, Md.</i>	
PHYSICIAN'S NAME (Type) <i>J. BRADY SMITH</i>		DATE SIGNED <i>6/12/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>June 14-1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Stomine Park</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>K. Surgee</i> ADDRESS <i>3631 Fells Road</i>		24a. REC'D BY REGISTRAR <i>IN 14 1957</i> DATE <i>6/12/57</i>	
24b. REGISTRAR'S SIGNATURE <i>K. M. Joyce</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. C. General Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SUSIE</u> Middle <u>Scott</u> Last <u>Scott</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-27-1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Churchton, Md. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Blunt</u>		14. MOTHER'S MAIDEN NAME <u>Mary Atlas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Frank Blunt - Churchton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACEREBRAL HEMORRHAGE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>241X CHRONIC ASTHMATIC BRONCHITIS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MARCH</u> , 19 <u>57</u> , to <u>JUNE 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JUNE 17</u> , 19 <u>57</u> , and that death occurred at <u>5:00</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Hudson</u> M.D.		ADDRESS (Street, city or town, state) <u>68 FRANKLIN ST. ANNAPOLIS, MD.</u>	
DATE SIGNED <u>6/17/57</u>			
PHYSICIAN'S NAME (Type) <u>William Reese, Jr. - Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-21-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Franklin</u>	22d. LOCATION (City, town, or county) (State) <u>Churchton</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>Wm. J. Church</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. Church</u>	
DATE <u>JUN 20 1957</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5871 Items 5, 6 Film G217 7-2-57 et
CERTIFICATE OF DEATH

Reg. Dist. No. 05917

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ADAPPOSIS</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>H.A. General</u>		d. STREET ADDRESS <u>Harwood Md. x0</u>	
3. NAME OF DECEASED (Type or print) <u>BENJAMIN</u> First Middle Last		4. DATE OF DEATH <u>JUNE 21</u> Month Day Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 17 1913</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>	
11. BIRTHPLACE (State or foreign country) <u>Harwood</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph A SIMMS</u>		14. MOTHER'S MAIDEN NAME <u>M Martha E Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-14-3391</u>	
17. INFORMANT <u>Joseph E SIMMS JR.</u> Address <u>Harwood Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chedecase arrest</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>acute Bronchial asthma</u> DUE TO (c) <u>Purulent Bronchitis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>502.1</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 18</u> , 1957, to <u>June 21</u> , 1957; that I last saw the deceased alive on <u>June 20</u> , 1957, and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emily H. Wilson</u> M.D.		ADDRESS (Street, city or town, state) <u>Lothman, Ind.</u> DATE SIGNED <u>6-22-57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/23/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chews</u>		22d. LOCATION (City, town, or county) (State) <u>Chewsville Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin H. Galsworthy</u> ADDRESS <u>Chewsville Ind</u>		24a. REC'D BY REGISTRAR <u>JO - J. Galsworthy</u> DATE <u>6/26/57</u>	
		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1880		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		JUN 10 1925		BALTIMORE, MD.	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS ILLNESS	
JAMES H. HARRIS		MARY J. HARRIS		HIGH SCHOOL		METHODIST		MARRIED		NONE	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF MINISTER		NAME OF CLERGYMAN		NAME OF FUNERAL HOME		NAME OF BURIAL PLACE	
JUN 12 1925		BALTIMORE, MD.		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERGYMAN		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. 5

JUN 22 1925

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05918

CERTIFICATE OF DEATH

Reg. Dist. No. 21

5872

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>72 Southgate Ave.</u>				d. STREET ADDRESS <u>72 Southgate Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>H</u> Last <u>SMALL</u>				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1888</u>		9. AGE (In years lost birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick mason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Thomas Small</u>				14. MOTHER'S MAIDEN NAME <u>Ella Jewell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>William A. Samll- Son - same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 1/2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-10-</u> , 19 <u>57</u> , to <u>6-11-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-10-</u> , 19 <u>57</u> , and that death occurred at <u>2:05</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>6/13/57</u>							
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.				PHYSICIAN'S NAME (Type) <u>James R. Martin</u> <u>2 Shaw Street Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>Annapolis, Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 14 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Am J. Lenz</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

21

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation	
John Thomas Smith		July 12, 1925		Male		White		Married		Farmer	
Place of Birth		Date of Death		Time of Death		Cause of Death		Manner of Death		Place of Death	
Baltimore, Md.		July 15, 1967		10:30 AM		Heart Attack		Natural		Home	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Medical Examiner		Signature of Burial Officer	
<i>[Signature]</i>		<i>[Signature]</i>		<i>[Signature]</i>		<i>[Signature]</i>		<i>[Signature]</i>		<i>[Signature]</i>	
Date of Certificate		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Return	
July 16, 1967		July 16, 1967		July 16, 1967		July 16, 1967		July 16, 1967		July 16, 1967	

BUREAU V. S.

JUN 14 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5927

CERTIFICATE OF DEATH

05919

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1220 Lewis Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dallas Middle Smith Last Smith				4. DATE OF DEATH Month 6 Day 10 Year 1957			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 8, 1908	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevedore				10b. KIND OF BUSINESS OR INDUSTRY — — —		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Henry Williams				14. MOTHER'S MAIDEN NAME Alene Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or date of service) WWII				16. SOCIAL SECURITY NO. 217-12-206		17. INFORMANT Hospital Records Address State Hospital Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Hypertension 447X						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6/6 , 19 57 , to 6/10 , 19 57 , that I last saw the deceased alive on 6/8 , 19 57 , and that death occurred at 2:45 a. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 6/10/57 ACTUAL SIGNATURE Ludwig Benedict M.D. PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) 6/13/57		22b. DATE OF THE DEATH 6/13/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law				ADDRESS 302 Madison St. Balt.		24a. REC'D BY REGISTRAR DATE 6/12/57	
						24b. REGISTRAR'S SIGNATURE R. M. J...	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

JUN 12 1957

RECEIVED

5928

CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 17yrs. 11mos. 14days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. STREET ADDRESS Not given	
3. NAME OF DECEASED (Type or print) First Randall Middle Smith Last Smith		4. DATE OF DEATH Month 6 Day 5 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1875?
9. AGE (In years last birthday) 82? yrs.		10. IF UNDER 1 YEAR Months 6 Days 5 Hours 57 Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not given		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Not given		14. MOTHER'S MAIDEN NAME Not given	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Crownsville State Hospital		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Senile Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 450.0 (c) 571.1	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diarrhea of Undetermined Etiology		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 571.1	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. TIME OF INJURY Month, Day, Year Hour 6 a. m. 19 p. m.	
23c. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		23d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1/22	
23e. (City or town) 6/5		23f. (County) (State)	
21. I certify that I attended the deceased from 6/4 , 19 57 , to 6/5 , 19 57 , that I last saw the deceased alive on 6/4 , 19 57 , and that death occurred at 6:30 a.m. , from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) Crownsville, Md.	
23. ACTUAL SIGNATURE Ludwig Benedict, M. D.		24. DATE SIGNED 6/5/57	
25a. BURIAL, CREMATION, REMOVAL (Specify) 6/7/57		25b. DATE THEREOF 6/7/57	
25c. NAME OF CEMETERY OR CREMATORY Crownsville State Hospital		25d. LOCATION (City, town, or county) (State) Crownsville, Md.	
26. FUNERAL DIRECTOR'S SIGNATURE H. M. Long		26a. REC'D BY REGISTRAR 6/10/57	
26b. ADDRESS Crownsville, Md.		26c. REGISTRAR'S SIGNATURE U. M. Jones	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Name of Deceased		Date of Death	
John J. Jones		June 11, 1957	
Age		Sex	
65		Male	
Race		Color	
White		White	
Place of Birth		Usual Residence	
Baltimore, Md.		Baltimore, Md.	
Cause of Death		Manner of Death	
Heart Disease		Natural	
Immediate Cause		Underlying Cause	
Myocardial Infarction		Heart Disease	
Duration of Illness		Period of Incubation	
10 Days		None	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

BUREAU V. 2

JUN 11 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05921

5929

CERTIFICATE OF DEATH

Reg. Dist. No. 88

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Seneca</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Seneca</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Miller'sville</i>		LENGTH OF STAY (in this place) <i>4 1/2 months</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Marely Park Glen Burnie</i>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Sanna's Nursing Home</i>				STREET ADDRESS (If rural give location) <i>115 Holland Road</i>			
3. NAME OF DECEASED (Type or Print) <i>Mary Snider</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>6 12 57</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>		8. DATE OF BIRTH <i>May 6, 1882</i>	
9. AGE last birthday <i>75</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>James Wisar</i>		14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>James Crabbs Glen Burnie, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
490X IMMEDIATE CAUSE (A) <i>Lobar Pneumonia</i>				INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs</i>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Diabetes - Hypertension</i>							
19a. DATE OF OPERATION <i>260X</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>April</i> , 19 <i>55</i> , to <i>June</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6-11</i> , 19 <i>57</i> , and that death occurred at <i>10:45</i> A.M. from the causes and on the date stated above.							
SIGNATURE <i>Charles P. McDonald</i> M.D.				ADDRESS (Street, city, town, state) <i>Glen Burnie Md.</i> DATE SIGNED <i>6-12-57</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>6-16-57</i>		NAME OF CEMETERY OR CREMATORY <i>Baust Cemetery</i>		LOCATION (City, town, or county) (State) <i>Tyrone Maryland</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>J. M. Jago</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Merwyn C. Fawcett</i>		ADDRESS	
DATE <i>JUN 17 1957</i>							

CERTIFICATE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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BUREAU V. B.

JUN 17 1957

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5873

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital, Annapolis, Md.</u>				d. STREET ADDRESS <u>Apt. F-5, Perry Circle</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Hammond</u> Last <u>Stokes</u>				4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-17-57</u>		9. AGE (In years last birthday) yrs. <u>6</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>48</u>	IF UNDER 24 HRS. Hours <u>48</u> Min. <u>48</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Charles Randle Stokes</u>				14. MOTHER'S MAIDEN NAME <u>Patricia Hammond McCarthy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>U. S. Naval Hospital, Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>six hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>6-17</u> , 19 <u>57</u> , to <u>6-17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-17</u> , 19 <u>57</u> , and that death occurred at <u>11:48 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Francesco De Paola</u> M.D.				ADDRESS (Street, city or town, state) <u>6-17-57</u>			
DATE SIGNED <u>6-17-57</u>							
PHYSICIAN'S NAME (Type) <u>Francesco (n) De Paola LT MC USNR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Naval Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>JUN 20 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>Wm. J. Lench</u>			

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5930

CERTIFICATE OF DEATH

05923

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 2mos.17days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Simon Middle Sturgis Last Sturgis				4. DATE OF DEATH Month 6 Day 12 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Not given	
9. AGE (In years last birthday) 29? yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY — — —	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or, if unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive lung metastasis 193x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Neurofibrosarcoma left shoulder girdle DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple abscesses incident to above							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			20g. (City or town) (County) (State)				
21. I certify that I attended the deceased from March 26, 19 57 to 6/12 , 19 57 , that I last saw the deceased alive on 6/12 , 19 57 , and that death occurred at 9:55p.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ludwig Benedict				ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 6/13/57	
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6/18/57		22c. NAME OF CEMETERY OR CREMATORY Crownsville State Hosp		22d. LOCATION (City, town, or county) (State) Crownsville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. Heng				ADDRESS Crownsville, Md.		24a. REC'D BY REGISTRAR DATE 6/18/57	
24b. REGISTRAR'S SIGNATURE J. M. Gyles							

BUREAU V. S.

JUN 19 1957

RECEIVED

5874

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN IB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>LOUISE</u> Last <u>SULLIVAN</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/10/1900</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTH PLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Butler Marshall</u>				14. MOTHER'S MAIDEN NAME <u>Daisy Beck Marshall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Howard E. Sullivan, Davidsonville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>Arteriosclerotic Vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>447X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/17</u> , 19 <u>57</u> , to <u>6/25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/25</u> , 19 <u>57</u> , and that death occurred at <u>7:55 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Maurice F. Klavans</u> M.D.				ADDRESS (Street, city or town, state) <u>31 South 9th St. Annapolis, Md.</u> DATE SIGNED <u>6/25/57</u>			
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAUVANS, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hyson Co.</u> ADDRESS <u>1300-N St. N.W.</u>				24a. REC'D BY REGISTRAR <u>JUN 28 1957</u> DATE		24b. REGISTRAR'S SIGNATURE <u>John J. French</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death statistics, including fields for name, age, sex, race, cause of death, and place of death. The form is filled out with handwritten information.

NAME: MARY LOUISE SULLIVAN
AGE: 61
SEX: F
RACE: W
PLACE OF BIRTH: ILLINOIS
PLACE OF DEATH: ILLINOIS
DATE OF DEATH: JUNE 27 1957
CAUSE OF DEATH: ...

BUREAU V. S.

JUN 27 1957

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MANUALLY F. K. 100-100000

5875

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Peter SUSCAVAGE		4. DATE OF DEATH June 1, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1913
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR: Months 4 Days 1 Hours 1 Min. 1957	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY Md Drydock	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Victor SUSCAVAGE		14. MOTHER'S MAIDEN NAME Era Kasulin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 187-036628	
17. INFORMANT MRS. Grace Suscavage		Address 110 #2 Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, generalized DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Perforation of stomach DUE TO 3 days (c) Adenocarcinoma of stomach		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 576X	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-23- , 19 57 , to 6-1- , 19 57 , that I last saw the deceased alive on 5-31- , 19 57 , and that death occurred at 12:13 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jesse L. Wilkins M.D.		DATE SIGNED June 1, 1957	
PHYSICIAN'S NAME (Type) JESSE L. WILKINS		98 Cathedral St. Baltimore, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 4-1957	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE R. B. Singleton		ADDRESS Glen Burnie, Md.	
24a. REC'D BY REGISTRAR 1957		24b. REGISTRAR'S SIGNATURE M. J. French	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5233

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1912		BALTIMORE, MD.	
MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
YES		JUN 10 1935		BALTIMORE, MD.		JUN 10 1957		BALTIMORE, MD.		HEART DISEASE	
OCCUPATION		EDUCATION		RELIGION		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
CLERK		HIGH SCHOOL		METHODIST		NATURAL		12345		YES	
PREVIOUS ILLNESS		DATE OF ONSET		DATE OF LAST EXAMINATION		DATE OF LAST TREATMENT		DATE OF LAST VISIT		DATE OF LAST EXAMINATION	
NONE		JUN 10 1957		JUN 10 1957		JUN 10 1957		JUN 10 1957		JUN 10 1957	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
JUN 10 1957		BALTIMORE, MD.		HEART DISEASE		NATURAL		12345		YES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
JUN 10 1957		BALTIMORE, MD.		HEART DISEASE		NATURAL		12345		YES	

BUREAU V. 3

JUN 4 1957

RECEIVED

RECEIVED BY OFFICE OF
ATLANTIC STATE DEPARTMENT OF HEALTH
BALTIMORE, MD.
JUN 10 1957

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05926

5876 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <i>Annapolis</i>		LENGTH OF STAY (in this place) <i>37 days</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>XO Jewell Md.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Anne Arundel General Hosp</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i>Albert Wilson Taylor Sr</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>June 4 19 57</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>April 23, 1876</i>	9. AGE last birthday <i>81</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Zachary Taylor</i>				14. MOTHER'S MAIDEN NAME <i>Martha Robinson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mr. Albert Taylor, Danville, Va</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
585X IMMEDIATE CAUSE (A) <i>cholecystectomy, infected gall bladder</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <i>coronary thrombosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>4-30-57</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>April 30, 19 55</i> , to <i>June 4, 19 57</i> ; that I last saw the deceased alive on <i>June 4, 19 57</i> , and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Emily H. Wilson</i>				ADDRESS (Street, city, town, state) <i>Lothian, Md</i>		DATE SIGNED <i>6-5-57</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>		DATE THEREOF <i>June 6, 1957</i>		NAME OF CEMETERY OR CREMATORY <i>Friendship</i>		LOCATION (City, town, or county) (State) <i>Friendship Md</i>	
24. REC'D BY REGISTRAR <i>6/5/57</i>		REGISTRAR'S SIGNATURE <i>H. W. Ward</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. A. Hutchins</i>		ADDRESS <i>Owings Md.</i>	

CERTIFICATE OF DEATH

WYOMING STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

REGISTRATION No.

1. NAME OF DECEASED (Print Name)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF CHURCH

20. SIGNATURE OF OTHER

BUREAU V. 8

JUN 7 1957

RECEIVED

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 17. JATRON 20 MARCH 1957
 18. JATRON 20 MARCH 1957
 19. JATRON 20 MARCH 1957
 20. JATRON 20 MARCH 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5877

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05927

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>A.A.CO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 BROOKLYN PARK</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>15208 Ritchie Highway-</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>Raymond</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>6</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 17, 1913</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Raymond Taylor</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>UW-11</u>		17. INFORMANT <u>Mrs. THELMA TAYLOR</u> Address <u>5208 Ritchie Hwy</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART DISEASE</u> <u>434.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 17, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gonce</u> <u>George J. Gonce</u>				ADDRESS <u>4001 Ritchie Hwy</u>		24. REG'D BY REGISTRAR <u>MD</u> DATE <u>6/13/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Thos. L. Funch</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUN 21 1957
BUREAU V. 3.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		HOURS	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		FINDINGS	
HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		TOXICOLOGY		POSTMORTEM FINDINGS	
FAMILY HISTORY		SOCIAL HISTORY		MENTAL STATUS		GROSS FINDINGS		MICROSCOPIC FINDINGS	
PREVIOUS ILLNESS		MEDICATION		SUSPECTED POISON		TOXIC SUBSTANCES		OTHER FINDINGS	
SIGNATURE OF EXAMINER		TITLE		DATE		PLACE		HOURS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5931

CERTIFICATE OF DEATH

05928

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 3yrs.4mos.12days		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15562		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Herbert Thornton		4. DATE OF DEATH Month Day Year 6 19 1957		5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/25/20		9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Henry Thornton		14. MOTHER'S MAIDEN NAME Cornelia Jackson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Tuberculosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asthma, Asthenia 241X		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 7/16 , 19 56 , to 6/19 , 19 57 , that I last saw the deceased alive on 6/19 , 19 57 , and that death occurred at 7:10p M, from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ACTUAL SIGNATURE Lionel McHenry Mapp		ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 6/20/57		M.D.	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		22a. BURIAL, CREMATION, REMOVAL (Specify) 6-24-57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery, Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Jones Co.		ADDRESS 1432-You St. N.W.		24a. REC'D BY REGISTRAR 25 1957		24b. REGISTRAR'S SIGNATURE R. M. Jones	

CERTIFICATE OF DEATH

BUREAU V. 2

JUN 25 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5932

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05929

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>One hour</u>				d. STREET ADDRESS <u>2013 Kernan Drive</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Savern River</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dale Franklyn Turley</u>				4. DATE OF DEATH Month Day Year <u>June 30th 1957 19</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/8/40</u>	
9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Harold E. Turley</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Maybelle Webb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>219-26-2604</u>		17. INFORMANT Address <u>Mr. and Mrs. H.E. Turley, (parents).</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> DUE TO <u>929.8</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowning (Developed cramps)</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>12.43 6/30th 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Saverna Park, A.A. Md.</u>		20f. (City or town) (County) (State) <u>Saverna Park, A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>June 30th 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-3-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Howard Strong</u> ADDRESS <u>3707 W. North Ave</u>				24a. REC'D BY REGISTRAR <u>AUL 2 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Adkins</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05930

5933

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>a-a.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 PASADENA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HAUREL DRIVE-PINE HAVEN</u>				e. STREET ADDRESS <u>HAUREL DRIVE PINE HAVEN</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR T. TURLINGTON</u>				4. DATE OF DEATH Month Day Year <u>JUNE 21 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 14-1883</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER RET</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CAN CO</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>THOMAS W. TURLINGTON</u>				14. MOTHER'S MAIDEN NAME <u>JANNIE DAVIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT <u>JAMES T. TURLINGTON</u>				Address <u>3833 FERNDALE AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>10 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331x</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>JUNE 19, 1957</u> to <u>JUNE 21, 1957</u> , that I last saw the deceased alive on <u>JUNE 19, 1957</u> , and that death occurred at <u>9:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Brady Smith</u>				M.D. <u>RIVIERA BEACH MD</u>			
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>				ADDRESS (Street, city or town, state) <u>RIVIERA BEACH MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-25-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Cem</u>		22d. LOCATION (City, town, or county) (State) <u>19atto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. M. Walters</u>				ADDRESS <u>19atto Md</u>		24a. REC'D BY REGISTRAR <u>J. J. Sealbas</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. J. Sealbas</u>		DATE <u>JUN 24 1957</u>	

RECEIVED

5878

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>General Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John A. Turner</u>				4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-11-1921</u>	
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>36</u>		IF UNDER 24 HRS. Hours <u>36</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Yacht Club</u>			
11. BIRTHPLACE (State or foreign country) <u>Bristol, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Oliver Turner</u>				14. MOTHER'S MAIDEN NAME <u>Florence Owens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>230-168845</u>			
17. INFORMANT <u>Margie Brown</u>				Address <u>Anne, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO <u>vascular disease</u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3/15</u> , 19 <u>57</u> , to <u>6/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/7</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore H. Johnson, Jr.</u> M.D.				ADDRESS (street, city or town, state) <u>37 Calver Street, Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Theodore H. Johnson, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moses</u>		22d. LOCATION (City, town, or county) (State) <u>Drewing, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>				ADDRESS <u>Anne, Md.</u>		24. RECEIVED BY REGISTRAR <u>JUN 13 1957</u>	
25. REGISTRAR'S SIGNATURE <u>Mon. J. French</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05932

5879 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ERNEST First Middle Last WALSH		4. DATE OF DEATH June 19 19 57 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 8th 1925 9. AGE (In years last birthday) 32 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ROUTEMAN		10b. KIND OF BUSINESS OR INDUSTRY CARLING BREWERY	
11. BIRTHPLACE (State or foreign country) WASHINGTON, DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William WALSH		14. MOTHER'S MAIDEN NAME ALMA WALSH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. GERALDINE WALSH 17. INFORMANT RT.1. EDGEWATER, MD. Address Box 270 F.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Phosphorus Poisoning 971.8 DURIOR Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute alcoholism DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) Phosphorus poisoning	
20c. TIME OF INJURY Month, Day, Year Hour 6/19/57 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown		20f. (City or town) Annapolis (County) A.A. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Paul F. Guerin M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M. D.		DATE SIGNED 6/19/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) 6-24-57		22b. DATE THEREOF ARLINGTON NATIONAL 22c. NAME OF CEMETERY OR CREMATORY ARLINGTON VIRGINIA 22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Matthew Haulon ADDRESS 3831- 20 Ave NW		24a. REC'D BY REGISTRAR JUN 26 1957 24b. REGISTRAR'S SIGNATURE Tom J. French	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUN 26 1957
BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5934

CERTIFICATE OF DEATH

05933

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 7yrs.6mos.3days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		3y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 404 N. Durham Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gertrude Middle Washington Last Washington		4. DATE OF DEATH Month 6 Day 19 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/29/90
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Preacher		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Not given		14. MOTHER'S MAIDEN NAME Not given	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address State Hospital Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 522X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Senility and Malnutrition (b) Senility and Malnutrition DUE TO (c) ---			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. n. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/12 , 19 57 , to 6/19 , 19 57 , that I last saw the deceased alive on 6/19 , 19 57 , and that death occurred at 2:45p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp		ADDRESS (Street, city or town, state) Crownsville, Md.	
DATE SIGNED 6/19/57			
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Emb.		22b. DATE THEREOF 6-20-57	
22c. NAME OF CEMETERY OR CREMATORY W. B. M. Hospital		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese #108 W. 20th St. Annapolis		24a. REC'D BY REGISTRAR DATE 6/21/57	
24b. REGISTRAR'S SIGNATURE A. M. Jones			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

BUREAU V. S.

JUN 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5880

CERTIFICATE OF DEATH

Reg. Dist. No.

05934
21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 Hill Street		d. STREET ADDRESS 2 Hill Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle L Last WELLS		4. DATE OF DEATH Month JUNE Day 18 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1882
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Levy		14. MOTHER'S MAIDEN NAME Mary Barbars (unknown) MORAVETZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Daniel W. Wells- Husband- same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS, GENERALIZED DUE TO (c) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954 to 18 JUNE 1957 , that I last saw the deceased alive on 18 June 1957 , and that death occurred at 5:12 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 41 Southgate Ave. Annapolis, Maryland DATE SIGNED 6-19-57			
ACTUAL SIGNATURE Edward S. Beck M.D. 4			
PHYSICIAN'S NAME (Type) Edward S. Beck			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 21, 1957	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE JUN 20 1957	
24b. REGISTRAR'S SIGNATURE Tom J. French			

RECEIVED

JUN 20 1957

BUREAU V. 3

TO HOF
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TO FUNER

VS A15
15M 9/2

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24
ed by the hospital or attending physician.
IRECTOR: After this certificate has been signed by the attending physician and completely filled
d be detached for use as it is permitted to remove the certificate from the file.

after death: Page

he funeral director,

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A A</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A A</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A A General</u>		d. STREET ADDRESS <u>RT 3 Box 630</u>	
3. NAME OF DECEASED (Type or print) <u>MATTHEW JOHN WILMER</u>		4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>54</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELL DRILLER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Phil'd Pa.</u>	
13. FATHER'S NAME <u>George W. WILMER</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET CASSIDY Edgewater MD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW1</u>	
17. INFORMANT <u>ANNA C. WILMER</u>		Address <u>RT 3 Box 630 Edgewater MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS = MYOCARDIAL INFARCTION</u> DUE TO <u>420.1</u> (b) <u>HYPERTENSIVE CARDIO-VASCULAR DISEASE</u> DUE TO <u>490.8</u> (c) <u>LOBAR PNEUMONIA, RIGHT LUNG</u>		INTERVAL BETWEEN ONSET, AND DEATH <u>4 DAYS</u> <u>2 YRS.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT. 1952</u> , to <u>30 JUNE 1957</u> , that I last saw the deceased alive on <u>30 JUNE 1957</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck</u>		DATE SIGNED <u>6/30/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/1/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>US National</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bruce Hardisty Guilford Md</u>		24. READ BY REGISTRAR <u>APR 11 1958</u> REGISTRAR'S SIGNATURE <u>V. J. ...</u>	

5935

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 32yrs. 2mos. 20days Perryville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Not given			
3. NAME OF DECEASED (Type or print) First Adam Middle Wilson Last Wilson				4. DATE OF DEATH Month 6 Day 28 Year 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1880	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not listed		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records Address Crownsville State Hospital Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/3 , 19 57 , to 6/28 , 19 57 , that I last saw the deceased alive on 6/27 , 19 57 , and that death occurred at 6:30a. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 6/28/57 ACTUAL SIGNATURE Cyril G. Hardy M.D. PHYSICIAN'S NAME (Type) Cyril G. Hardy, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7/3/57		22c. NAME OF CEMETERY OR CREMATORY Crownsville State Hospital Crownsville Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Lee ADDRESS William Lee				24a. REC'D BY REGISTRAR DATE 7-5/57		24b. REGISTRAR'S SIGNATURE L. M. Jones	

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH-BALTIMORE 18

Name of Deceased		Age		Sex		Race		Date of Birth		Place of Birth	
John Doe		45		Male		White		1912		Maryland	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Date of Death		Place of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		July 7, 1957		Home	
Physician's Signature		Physician's Name		Physician's Address		Physician's City		Physician's State		Physician's Zip	
John Smith		Dr. John Smith		123 Main St.		Baltimore		Maryland		21201	
Funeral Home Signature		Funeral Home Name		Funeral Home Address		Funeral Home City		Funeral Home State		Funeral Home Zip	
ABC Funeral Home		ABC Funeral Home		456 Oak St.		Baltimore		Maryland		21202	
Registrar's Signature		Registrar's Name		Registrar's Address		Registrar's City		Registrar's State		Registrar's Zip	
John Doe		John Doe		123 Main St.		Baltimore		Maryland		21201	

BUREAU V. S.

JUL 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5936

05936

Item 1 FilmG218 7-18-57 et

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>AA Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PACO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elmer.</u> Middle <u>M.</u> Last <u>WINES</u>				4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 12, 1916</u>	
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Warrenton, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Elmer M. Wines</u>				14. MOTHER'S MAIDEN NAME <u>Nellie V. Trammell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Pearl M. Wines</u>				Address <u>Edgewater, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. [Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. [Signature]</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 3, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan</u>				ADDRESS <u>317 Penna. Ave. S.E.</u>		24a. REC'D BY REGISTRAR <u>Dr. Wm. C. French</u>	
				DATE <u>7/3/57</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. C. French</u>	

DATE SIGNED

6/30/57

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. TITLE OF EXAMINER		15. DATE OF EXAMINATION	
16. SIGNATURE OF NEXT OF KIN		17. TITLE OF NEXT OF KIN		18. SIGNATURE OF WITNESS		19. TITLE OF WITNESS		20. DATE OF SIGNATURE	

BUREAU V. 3

JUL 3 1957

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